

**Schreiber Pediatric Rehab Center
Portable Medical Profile**

I. Demographic Information

A. Client _____ DOB _____

II. Family Composition and History

A. Please list all people living with the child in your home.

Name	DOB	Relationship	Workplace/School
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

B. Is Your Child Adopted____ Foster Care____

Date of Adoption _____ Date placed in Foster Care _____

C. If child is living with only one biological parent, name and address of other parent?
(If involved with child).

D. Are there any cultural preferences or considerations of which we should be aware?

E. Please list any history of hearing loss, speech delay, fine or gross motor problems and/or learning difficulty by any members of your family living or deceased.

Family Member	Problem	Treatment/Meds
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

III. Pre-School / School Information

A. School child attends _____

School District: _____ Grade _____

Teacher: _____ IU 13. Yes or No

B. Does your child receive Early Intervention: __yes __no

Birth to Three E.I. Support Coordinator _____

IU#13 Early Intervention Service Coordinator _____

C. Does your child receive any of the following supports in their school program?

- | | |
|---|---|
| <input type="checkbox"/> Life Skills | <input type="checkbox"/> Multi-Handicap |
| <input type="checkbox"/> Vision Support | <input type="checkbox"/> Resource Room |
| <input type="checkbox"/> Mobility Training | <input type="checkbox"/> Diag. Kindergarten |
| <input type="checkbox"/> Hearing Support | <input type="checkbox"/> Learning Support |
| <input type="checkbox"/> Autistic Support | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Speech Therapy |

IV. Agencies, Hospitals, and/or Other Programs involved with the child and/or family and dates of attendance

___ Primary Care Provider (name) _____

Practice / Address _____

___ Medical Specialist (specialty) _____ (name) _____

Practice / Address _____

___ Medical Specialist (specialty) _____ (name) _____

Practice / Address _____

___ Medical Specialist (specialty) _____ (name) _____

Practice / Address _____

___ Medical Specialist (specialty) _____ (name) _____

Practice / Address _____

___ Medical Specialist (specialty) _____ (name) _____

Practice / Address _____

___ Physical Therapy _____

___ Occupational Therapy _____

___ Speech/Language Therapy _____

___ Feeding Clinic _____

___ Children & Youth Services _____

___ Church Support Groups _____

___ Other Support Groups _____

___ Other Family Support Services _____

V. Child's Birth & Medical History

A. Pregnancy / Delivery

Length of Pregnancy: _____

Duration of Labor: _____

Birth Weight ____ lbs. ____ oz. ____ inches

Anesthesia Used: _____

B. Hospital of Birth: _____

Specialized Care or NICU _____ How Long: _____

C. Type of Delivery: ____ Natural ____ Induced ____ Caesarean Section

D. Did you receive any pre-natal care Yes or No

*Please answer the following questions if you experienced any complications during your pregnancy which you would like to share with the therapist(s).

E. Pregnancy:*

____ Illness _____

____ Medications _____

____ Asthma _____

____ Heart Problems _____

____ Premature Contractions _____

____ Bleeding _____

____ Amniocentesis _____

____ Genetic Counseling _____

____ Mental Health/Stress _____

____ Other Difficulties _____

F. Did your child experience any of the following:

____ Premature Birth

____ Need Resuscitation or Difficulty breathing upon delivery

____ Jaundice

____ Sucking/Swallowing Problems

____ Breech

____ Frequent Illness _____

____ History of Ear Infections _____

____ Feeding Problems _____

____ Other: _____

G. Medical History

1. Diagnosis(es) _____

2. Current Medications (name, dosage, frequency)

3. Hospitalizations or Surgeries:

Name	Dates	For What?
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4. Immunizations: Are your child's immunizations up to date? ___ yes / ___ no

5. Allergies

6. What Equipment or Devices does the child use to help him access his/her environment (wheelchair, crutches, hearing aid, prosthesis, communication device, etc.)

7. What is the child's functional status?

Area	Age Appropriate	Slightly Delayed	Moderately Delayed	Significantly Delayed
Gross Motor				
Fine Motor				
Self-Care				
Communication				
Personal/Social				
Swallowing/Feeding				
Vision				
Hearing				

Comments:

V. Emergency Information

A. Please indicate two persons who we may contact in case of emergency and parent/guardian is not present.

Name	Relationship	Address	Phone
_____	_____	_____	_____
_____	_____	_____	_____

B. In the event that your child needs to be taken to the hospital, unless otherwise indicated, they will be transported to the closest hospital by emergency medical personnel.

Hospital Choice _____

C. Does your child / parents or legal guardian on behalf of child have an advanced directive (eg., Do Not Resuscitate order (DNR), etc.) yes / no

If so, is it applicable in this setting? yes / no

If yes, it is the responsibility of the family to provide this legal document to the Social Services Department upon enrollment in programming, and to keep the Center informed of updates to the order pursuant to our policy # _____.

VI. Health Insurance Information

A. Primary Insurance

Company _____
ID# _____
Group # _____
Name of Insured _____
Date of Birth _____
Employer _____

B. Secondary Insurance

Company _____
ID# _____
Group # _____
Name of Insured _____
Date of Birth _____
Employer _____

Date Updated _____ Signature of Responsible party _____
Printed Name _____

Date Updated _____ Initials _____
Date Updated _____ Initials _____
Date Updated _____ Initials _____
Date Updated _____ Initials _____