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?

__Life Skills	__Multi-Handicap
__Vision Support	__Resource Room
__Mobility Training	__Diag. Kindergarten
__Hearing Support	__Learning Support
__Autistic Support	__Physical Therapy
__Occupational Therapy	__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?

_____
_____
_____
_____
_____

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

5. Allergies

_____
_____
_____

6. What Equipment of 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 _____