Elizabeth Moberg-Wolff MD   Pediatric PM&R Visit Form – 1st Visit

Patient's Name: ______________________________ **Age:** __________ **DOB:**___________ **Today's Date:**________________

Referred by: ____________________________

Goals for Visit/Concerns: ____

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Patient's Diagnose/History: (Birth history/ Hospitalizations /Diagnostic tests,

Medications   **Allergies**   **Weight**   **Height**

Diet (special formula, texture etc)

Systems review – circle all that apply or that you need help with…

Sleep problems	Constipation	Weight/Nutrition	GI problem	Drooling	Respiratory issues
Scoliosis	Contractures	Gait problems	Spasticity	Pain	Behavior issues
Equipment issues	Brace tolerance	Skin breakdown	Vision issues	Seizure problems	
Attention problems	Respite care needs	Toileting issues	PT/OT issues	School issues	

Other____________________________________

Surgeries (shunt, g-tube, orthopedic, ear. eye, phenol/botox etc)

Other Medical Providers Names (orthopedist, neurologist, dentist, eye, etc)

Family History (genetic problems? learning issues? orthopedic issues, any other family members with disabilities?)

Social (Siblings? Other caregivers? Day care? Lives with?)

Orthotics (check those you have)

□ AFO □SMO □UCB □Wrist □ Elbow □ Theratogs/Spio/DMO etc □ TLSO □Neck brace

Adaptive Equipment: Vendor you use _____________________________ (Knuepple, National Seating etc)

□ Wheelchair (□ Manual/□ Power) □ Walker (Type: __________________________) □ Stroller

□ Stander □ Gait Trainer □ Crutches/Canes □ Night splints _____________________

□Bath/Shower Chair □ Car Seat □ Lift □ Other ____________________

Home modification: □ Ramped □ Hoyer lift □ Adapted bath □Adapted bed □ Need_________

Transportation: □ Car/ Van □ Public Transit □ Medical Van Have handicap parking? Y N

Communication □Verbal □Nonverbal □Device __________________ □ Other _______________

School/Day/Vocational program name: ____________________

□ Regular classes □ Has Aide □ Partial inclusion □ Special Ed □ Has IEP

Therapist's Name/location: ____ Phone: _________________________

Current Therapy:	PT	OT	Speech
Birth to 3 (frequency)			
School (frequency)			
Private (frequency)			

Therapy interventions tried □ Taping □ Casting □ E stim □ Hippotherapy □ Aquatic □ Other_________

Functional Abilities:

Activity	Independent	Minimal Assist	Dependent	Concerns
Bed Mobility				
Sitting				
Standing/Transfers				
Walking				
Stairs				
Running/balance				
Upper arm use Dressing, Writing Eating				
Communication				

Child's Strengths/Interests Any other important information we should know….

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Who would you like us to share information with? (therapist, primary physicians, specialists etc)

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THANK YOU!