Courage Kenny Rehabilitation Institute™ Pediatric Intake Form

Please answer the following questions to the best of your knowledge.

GENERAL INFORMATION

Person Completing Form:_____ Date:_____

Relationship To Patient:_____

Diagnosis/Conditions/Reasons you are seeking rehabilitation services for your child:

The primary **goal for my child** in therapy is (Things you would like your child to do in the home or community that they can't do right now):

Please list any restrictions your child's doctor(s) have given:

How does your child learn best? ☐ Reading ☐ Listening ☐ Demonstration ☐ Pictures

As a caregiver how do you learn best? ☐ Reading ☐ Listening ☐ Demonstration ☐ Pictures

As a caregiver do you have any learning difficulties or barriers? ☐ Yes ☐ No

If yes, please specify:_____

HEALTH HISTORY

Birth/Pregnancy History: At what week in the pregnancy was the patient born?_____

Were there complications with the pregnancy? ☐ Yes ☐ No If yes, please specify:

Were there any complications (problems) at birth? ☐ Yes ☐ No If yes, please specify:

Does your child receive primary care at an Allina Health Facility? ☐ yes, then skip to page 2. If no, then please fill out these sections.

Your Child's Past/Present Conditions

Heart Surgery	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Bleeding Disorder	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Thyroid Disorder	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No
Headaches/Migraines	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Seizures	☐ Yes	☐ No
Sleep Problems	☐ Yes	☐ No	Shunt	☐ Yes	☐ No	Recurrent Pneumonia	☐ Yes	☐ No
Reflux	☐ Yes	☐ No	Upper Respiratory Infections	☐ Yes	☐ No	CMV (Cytomegalovirus)	☐ Yes	☐ No
RSV	☐ Yes	☐ No	Cervical Spine Instability	☐ Yes	☐ No	Scoliosis	☐ Yes	☐ No
Fractures	☐ Yes	☐ No	Behavioral Concerns	☐ Yes	☐ No	Feeding Tube	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Anxiety	☐ Yes	☐ No	Sensory Concerns	☐ Yes	☐ No
Ear Infections	☐ Yes	☐ No	PE Tubes (ear tubes)	☐ Yes	☐ No			

ALLERGIES: Does your child have allergies (e.g., medications, latex, foods, environmental, etc.)? ☐ Yes ☐ No If yes, please list.

ALLERGY	REACTION
1.	
2.	
3.	
4.	
5.	

MEDICINES: Does your child currently take any medicine(s)? ☐ Yes ☐ No
If yes, please list. Continue on back if needed.

MEDICINE	DOSE	TAKEN FOR	MEDICINE	DOSE	TAKEN FOR
1.			4.		
2.			5.		
3.			6.		

SURGERIES/PROCEDURES: Has your child had any surgeries/procedures? ☐ Yes ☐ No
If yes, please list below. (including Botox or phenol injections, serial casting, PE tubes)

SURGERY/PROCEDURE	WHEN	SURGERY/PROCEDURE	WHEN
1.		4.	
2.		5.	
3.		6.	

PATIENT LABEL

Allina Health
COURAGE KENNY REHABILITATION INSTITUTE

59-01
Questionnaire

Whom have you seen (or are you seeing) for this problem?

☐ Medical doctor	☐ Nutrition	☐ Occupational therapist
☐ Physician assistant	☐ Speech/language pathologist	☐ Psychiatrist/psychologist
☐ Applied Behavior Analysis (ABA)	☐ Chiropractor	☐ Nurse practitioner
☐ Behavior Therapy	☐ Physical therapist	☐ Other_____

Your Child's Current Difficulties or Equipment

Trouble Seeing	☐ Yes	☐ No	Glasses/Contacts	☐ Yes	☐ No	Orthotics/Braces	☐ Yes	☐ No			
Trouble Hearing	☐ Yes	☐ No	Hearing Aid	☐ Yes	☐ No	Crutches	☐ Yes	☐ No			
Speech/Language	☐ Yes	☐ No	Communication Device	☐ Yes	☐ No	Walker	☐ Yes	☐ No			
Attention Problem	☐ Yes	☐ No	Splints	☐ Yes	☐ No	Wheelchair	☐ Yes	☐ No	☐ Other (specify)		

Feeding/Swallowing/Nutrition

Do you have feeding or swallowing concerns for your child? ☐ Yes ☐ No

Has your child experienced unexplained weight loss or gain in the past 6 months? ☐ None ☐ Loss ☐ Gain

If unexplained loss or gain, how many pounds? _____

Do you have any nutritional concerns for your child? ☐ Yes ☐ No If yes, please explain:_____

Is your child on a special diet? ☐ Yes ☐ No If yes, please explain:_____

Please check the box for each test your child has had for his or her condition:

☐ Video Fluoroscopic Swallow Study ☐ X-Ray ☐ MRI ☐ CT Scan ☐ EMG ☐ Neuropsychology ☐ Gait Lab

☐ Other_____

Has your child ever been on oxygen? ☐ Yes ☐ No If yes, for what reason? _____

Are there any other health problems you would like us to know about? ☐ Yes ☐ No If yes, please specify:

Does your child have any active infections (e.g., RSV, CMV, MRSA, VRE, C-DIFF, Other)? ☐ Yes ☐ No

If yes, please specify:

Does your child experience pain that is related to their condition? ☐ Yes ☐ No

If yes, please circle the number that describes your child's level of pain.

No Pain										***Unbearable Pain***
0	1	2	3	4	5	6	7	8	9	10

How does your child display pain? _____

How is your child calmed or soothed when in pain? _____

OTHER HISTORY

Developmental History: Was your child delayed in any of the following milestones?

Rolling	☐ Yes	☐ No	Babbling/Cooing	☐ Yes	☐ No	Drinking from a cup	☐ Yes	☐ No			
Sitting	☐ Yes	☐ No	Using words	☐ Yes	☐ No	Finger Feeding	☐ Yes	☐ No			
Standing	☐ Yes	☐ No	Using 2 word phrases	☐ Yes	☐ No	Using Utensils	☐ Yes	☐ No			
Walking	☐ Yes	☐ No				Toilet Training	☐ Yes	☐ No			

Education: School District:_____ Grade:_____

Is currently on an IFSP/IEP? ☐ Yes ☐ No

School/Agency Contact:_____ Contact Phone:_____

School-based therapies? ☐ Yes ☐ No If yes, which one(s)? (Include minutes of service per week or month):

☐ Occupational Therapy_____ ☐ Speech Therapy_____ ☐ Physical Therapy_____

Family/Social:

Is there anything or anyone in your home environment that causes **concern for you or your child's safety**? ☐ Yes ☐ No

If yes, explain:_____

Does your family have any **special cultural, religious, or spiritual practices/concerns** that you would like us to follow/address?

☐ Yes ☐ No If yes, please explain:

Child lives with: ☐ 1 parent ☐ 2 parents ☐ Foster parents ☐ Other adults in home (list):_____

☐ Siblings: # _____ and ages:_____

Has your child had more than one fall in the last 6 months unrelated to age appropriate mobility? ☐ Yes ☐ No. If yes - please explain:_____

PATIENT LABEL

Is your child currently experiencing any of the following?

Change in appetite? ☐ Yes ☐ No Change in sleep pattern? ☐ Yes ☐ No

Loss of interest in previously enjoyed activities? ☐ Yes ☐ No Feelings of hopelessness? ☐ Yes ☐ No

Are you concerned your child could be depressed? ☐ Yes ☐ No Have symptoms of anxiety ☐ Yes ☐ No If yes, please explain: _____

Are you concerned about your child's behavior? ☐ Yes ☐ No If yes, please explain: _____

Parent/Guardian Signature:	**Date:**

Review Date/Initials:	**Review Date/Initials:**	**Review Date/Initials:**
Review Date/Initials:	**Review Date/Initials:**	**Review Date/Initials:**

☐ **No reported concerns** **(FOR OFFICE USE ONLY)**

REPORTED CONCERNS	Patient agreed to MD referral; request sent to MD	Patient declined MD referral; info still sent to MD	Community resource info offered/provided	No referral necessary
☐ Significant unexplained weight loss	☐	☐	☐	☐
☐ Nutritional concerns	☐	☐	☐	☐
☐ Feeding/swallowing concerns	☐	☐	☐	☐
☐ Vision	☐	☐	☐	☐
☐ Hearing	☐	☐	☐	☐
☐ Health concerns	☐	☐	☐	☐
☐ Allergies	☐	☐	☐	☐
☐ Abuse/Neglect	☐	☐	☐	☐
☐ Behavioral	☐	☐	☐	☐
☐ Depression	☐	☐	☐	☐

Caregiver demonstrates a willingness to learn ☐ Yes ☐ No ☐ NA Patient demonstrates a willingness to learn ☐ Yes ☐ No ☐ NA

Caregiver is willing to participate in plan of care ☐ Yes ☐ No ☐ NA Patient is willing to participate in plan of care ☐ Yes ☐ No ☐ NA

Therapist Signature/Credentials:	**Date:**	**Time:**
Therapist Signature/Credentials:	**Date:**	**Time:**
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Therapist Signature/Credentials:	**Date:**	**Time:**
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PATIENT LABEL