Saint Alphonsus
Rehabilitation Services
179 SW 5th Ave ▪ Meridian, Idaho 83642 ▪ (208) 367-8282

PEDIATRIC PATIENT PROFILE

This profile is part of your child's medical record and is strictly confidential. Please answer the following questions to the best of your knowledge. Welcome to STARS!

IDENTIFIERS

Child's Name:_____ Birthdate: _____ Age: ____ Date: _____

Person Completing Form:_____

Relationship To Patient:_____

REASONS FOR REHABILITATION

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

_____

2. My primary **goal for my child** in therapy is: _____

3. What would you like your child to do at **home** that he/she cannot do right now (e.g., daily activities, hobbies, etc.)?_____

4. How about in the **community**? _____

5. Is there any **info/education** that you would like STARS to provide to you? ☐Yes ☐No
   If yes, please specify: _____

6. How would you like to have that information provided? ☐ Discussion ☐ Demonstration
   ☐ Written Literature ☐ Other (please specify): _____

SUMMARY LIST

Does your child now have (or has had) any of the following conditions: (Check)

Heart Surgery	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Asthma/Hayfever	☐ Yes ☐ No
Lung Disease	☐ 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
Bowel Problems	☐ Yes ☐ No	Seizures	☐ Yes ☐ No	Bladder Problems	☐ Yes ☐ No
Bronchiolitis	☐ Yes ☐ No	Sleep Problems	☐ Yes ☐ No	Diarrhea/constipation	☐ Yes ☐ No
Shunt	☐ Yes ☐ No	Recurrent Pneumonia	☐ Yes ☐ No	PEG/GI Tube	☐ Yes ☐ No
Reflux	☐ Yes ☐ No	Upper Respiratory Infections	☐ Yes ☐ No		
RSV	☐ Yes ☐ No	Cervical Spine Instability	☐ Yes ☐ No		

Does your child have any precautions or special accommodations of which we need to be aware?

☐**Yes** ☐**No** **If yes, please explain:**

ALLERGIES ☐Yes ☐No		**REACTION**
If yes, please list any allergies (to meds, latex, foods, products, etc.)and your child's reaction		
1.		
2.		
3.		
4.		
5.		

MEDICATIONS - Is your child currently taking any medications? ☐ Yes ☐ No

Medication	MD who Prescribed Medication	MD Phone Number (if available)

SURGERY/PROCEDURE – Has your child had any surgeries? ☐ Yes ☐ No		MONTH/YEAR
1		
2		
3		
4		

ADDITIONAL HEALTH QUESTIONS

Does your child have a history of choking? ☐Yes ☐No

Do you have any feeding or swallowing concerns for your child? ☐Yes ☐No If yes, please explain:

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

Has your child experienced unexpected weight loss or gain in the past 6 months? ☐None ☐Loss ☐Gain
If loss/gain, how many pounds? _____

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

Please check the box for each test your child has undergone for his/her condition:
☐VFSS ☐X-Ray ☐MRI ☐CT Scan ☐EMG ☐Other ☐NA

Has your child ever been on oxygen? ☐Yes ☐No

For what reason? _____

How would you describe your child's general health? ☐Good ☐Fair ☐Poor

Do you have a way to share your child's health information with other doctors/providers? ☐Yes ☐No

Note to Patient: If you DO have such a system or tool, please update your information or bring it in so we can assist you. If you DO NOT have such a system or tool, you will find options in your intake packet.

***Note: Please provide a copy of your child's immunization records.**

EQUIPMENT /NEEDS

Vision: ☐ No Visual Problems ☐ Glasses/Contact Lenses ☐ Visual Difficulties
Hearing: ☐ No Hearing Problems ☐ Hearing Aid ☐ Difficulty Hearing
Communication: ☐No Communication Problems

Special Communication Needs (please specify):_____

Does your child utilize any **assistive devices** (e.g., walker, crutches, wheelchair, cane, built-up utensil handles, etc.)? ☐Yes ☐No

If yes, please specify: _____

Other Needs (e.g., orthotics, prosthetics, etc.):

Patient Name (printed): _____ **DOB:** _____

MEDICAL SPECIALISTS (and phone numbers, if available)

PAIN ASSESSMENT

Does your child experience pain that is related to his/her condition? ☐Yes ☐No (If yes, please complete below.)

PAIN DESCRIPTION: *(Please Circle the Number that Describes your child's Level of Pain)*

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

How does your child display pain? _____

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

EDUCATION/SERVICES

Name of Preschool/School: _____ Grade: _____

Pre-school, school, service coordinator/agency contact info:

School/Agency Name: _____ Phone: _____

Previous or current outside services: ☐OT ☐ST ☐PT ☐DT

Provider Name: _____ Phone: _____

Are any of these services school-based? ☐Yes ☐No If yes, which one(s):

Preferred language: _____

Any specific cultural, religious, or spiritual practices/preferences of which we should be aware? Please specify:

Need for school services: ☐Yes ☐No If yes, referral was made (Initials: _____)

Patient Name (printed): _____ **DOB:** _____

Please check any concerns you have in the left hand column (white column) below. Ignore the grey columns as they are for office use only.

CONCERNS **Please Check all that apply:**	**(FOR OFFICE USE ONLY)**		**DOI: _____**
	Referral Made OR Patient encouraged to follow-up with PCP/ Other Provider	Community resource info offered/provided	NA or Additional follow-up beyond treatment is not necessary
☐ Swallowing/choking	☐	☐	☐
☐ Nutritional concerns	☐	☐	☐
☐ Unexplained weight change	☐	☐	☐
☐ Allergies	☐	☐	☐
☐ Health concerns	☐	☐	☐
☐ Depression	☐	☐	☐
☐ Anxiety	☐	☐	☐
☐ Safety	☐	☐	☐

Patient/Guardian Signature	**Date**	**Time**
Therapist Signature/Credentials	**Date**	**Time**

MODIFICATIONS/UPDATES

Date Reviewed:	Therapists Initials	Parent's or Guardian's Initials	Modifications were made during this review.	Section Modified
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	

Patient Name (printed): _____ DOB: _____