St. Luke's Rehabilitation Institute
INLAND NORTHWEST HEALTH SERVICES

Pediatric Health Summary

www.st-lukes.org

NAME: _____**DATE:** ___/___/_____ Age**:** _____ Sex ☐ M ☐ F

Name of Legal Guardian if patient is minor _____

Primary Phone: (____) _____ ☐ Mobile ☐ Home ☐ Other_____

Alternative Phone: (____) _____ ☐ Mobile ☐ Home ☐ Other_____

Email Address: _____

Emergency Contact: _____ (____) _____ _____
Name Phone # Relationship

LANGUAGE_____ **ETHNICITY: (Mark box below)**

☐Black/African American ☐Asian/Pacific American ☐White American
☐Native American/Alaskan Native ☐Latina/Latino/Hispanic American ☐Other_____

REFERRING PHYSICIAN: _____ **PRIMARY CARE PHYSICIAN:**_____

ALLERGIES: (Drug, Seasonal, Latex, or Food related**)**
☐NO ☐YES_____
HANDEDNESS: ☐ Right ☐ Left

REASON FOR THERAPY_____

WHAT ARE YOUR THERAPY GOALS?

_____

TRAVEL RISK SCREENING: Have you or someone you are in contact with traveled out of the country in the last 21 days? ☐ NO ☐ YES/LOCATION_____.

If YES, Are you or the person you are in contact with experiencing any of the following symptoms:

☐ Bleeding ☐ Diarrhea ☐ Vomiting/Stomach Pain
☐ Joint/Muscle pain ☐ Headache ☐ Rash
☐ Respiratory Symptoms ☐ Temp over 100.4F ☐ Conjunctivitis/Pink eye
Staff only: ☐ Referred to PCP_____

MEDICAL HISTORY: (Mark a box if you have had any of these conditions and explain below)

☐ Anxiety/Depression
☐ Arthritis
☐ Asperger's or Spectrum Disorder
☐ Asthma
☐ Cancer
☐ Diabetes Mellitus
☐ Eye disease
☐ Fetal Alcohol Syndrome
☐ Hearing loss/Chronic Ear Infections
☐ Heart Disease
☐ Impulsive/Inattentive or Aggressive Behavior
☐Injury Head
☐Injury Wrist/Hand
☐Injury Hip/Leg/Knee
☐Injury Foot/Ankle
☐Injury Shoulder
☐Injury Spinal/Neck
☐ Mental illness
☐ Nerve/Muscle Disease
☐ Pulmonary Disease
☐ Seizures
☐ Sensory Processing Disorder
☐ Stroke
☐ Tuberculosis
☐ Vision Loss

☐ Other (Please List) _____ Explain: _____
☐ Yes, the patient's immunizations are current ☐ No, the patient's immunizations are not current

SURGICAL HISTORY:

☐ Ear Surgery
☐ Eye Surgery
☐ Fracture Surgery
☐Brain Surgery
☐ Heart Surgery
☐ Small intestine Surgery

☐ Other (Please List) _____ Explain: _____

ADDRESSOGRAPH

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SOCIAL HISTORY: (Mark a box if you have had any of these conditions and explain below)
Exercise: ☐ 1 time per day ☐ Few times per week ☐ Few times per month ☐ Never
The patient lives with: _____
Siblings in the home: _____
Has the patient been exposed to:
☐ Physical/Emotional Abuse ☐ Alcohol or Substance Abuse ☐ Neglect
Do you have concerns with ☐transportation, ☐housing, or ☐financial? ☐ NO ☐ YES_____
Are you concerned about your safety or violence at home? ☐ NO ☐ YES_____
Are you experiencing difficulty coping with the patient's special needs? ☐ NO ☐ YES

BIRTH HISTORY: (Please mark if relevant & list condition)
☐ Preterm Delivery/delivered at how many weeks gestation: _____
☐ Patient was in Neonatal Intensive Care Unit _____

DEVELOPMENTAL HISTORY:
Please list any concerns regarding the patient's physical, language, social or emotional development (including delays in development, feeding, nutrition, weight gain, difficulty relating to others, problems at school) _____
_____
_____
Does your child have Individual Education Plan with his/her home school district? ☐ YES ☐ NO
What services are provided from the school district? _____
What School District is your child enrolled in? _____

MEDICATION LIST: (Please provide your complete list of Current Medications)

Medication/Injection	Dosage	Prescribing Physician	Phone Number
_____	_____	_____	(____) _____
_____	_____	_____	(____) _____
_____	_____	_____	(____) _____

SPECIAL NOTICE

Many insurances do not cover services when a child is referred for a delay in normal development or has a diagnosis showing neurological involvement. If your insurance plan does not specifically have a neurodevelopmental benefit (usually covers until age 7), then your regular benefit for therapy may not cover your child's diagnosis.
How to determine if your child's diagnosis will be covered by your regular therapy benefit:

1. If your child has normal function and it was lost due to an injury or illness, your regular therapy benefit may cover.
2. If your child is being referred because of a delay in normal development, such as speech delay (not talking or difficulty with talking) or lack of muscle strength, coordination or balance, then your child's therapy may not be covered under the regular therapy benefit. However, therapy may be covered if your policy has a neurodevelopmental benefit and your child meets the age requirement. This benefit usually requires prior authorization.

St. Luke's will submit all services to your insurance company. Please be aware that you are financially responsible if the services are not covered under your specific plan.

We have provided the following documents for your review: ***(Copies are available upon your request)***
☐Patient Rights and Responsibilities ☐Consent to Treat

_____ _____ __/__/___
Signature of Patient or Legal Guardian Relationship to patient Date

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