

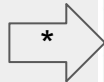


Patient Dashboard: How to Complete Pediatric Medical History

Before you begin:

Important:

- This History Form is comprehensive.
- Set aside **5-15 minutes of uninterrupted time** to complete it. Depending on complexity of your child's condition it could take less or more time.
- A Computer with Chrome browser provides the best experience, but you can complete it on a tablet or smartphone



Carolina Pediatric Therapy Patient Portal

Test SLI (Logged in as Summer McMurry)

Change Account Test SLI Time: 17:06:23

[Cambiar a Español](#) [Logout](#)

We don't have your medical history on file.
Please click on the button to add one.

Edit	Last Updated	Description
------	--------------	-------------

[Add Pediatric History](#)

***Records tab: *Medical History* Subtab**



Patient Dashboard: How to Complete Pediatric Medical History

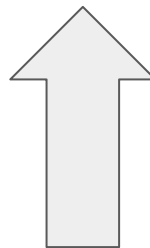
Reminders while completing:

Important:

- Click through and **Complete ALL 6 Tabs and 7 Sub-tabs** under the Developmental History Tab.
- This **MUST** be complete at least **48 hours BEFORE** your Scheduled Evaluation Appointment.
- Incomplete History may require us to reschedule your Evaluation to a later date.

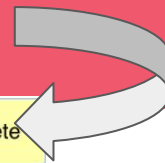
Pregnancy / Delivery Following Birth Medication/Allergies Tests/Procedures Medical Conditions **Developmental History**

Motor/Play Sensory/Social-Emotional Feeding Speech/Language Home Environment Equipment Therapy/School History



**Complete ALL Tabs BEFORE selecting
Save and Close History Button**

Click to Save and Close History Once Complete





Patient Dashboard: How to Complete Pediatric Medical History

1. Select **Add Pediatric History** button
2. This will open up the *Pediatric History Form*



Carolina Pediatric Therapy Patient Portal

Test SLJ (Logged in as Summer McMurry)

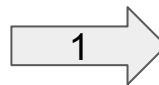
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We don't have your medical history on file.
Please click on the button to add one.

Edit	Last Updated	Description
------	--------------	-------------

[Add Pediatric History](#)



*Records tab: *Medical History* Subtab



Pediatric History: Tabs 1-3

← Medical History: Please complete this History First

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Click to Save and Close History Once Complete

Pregnancy / Delivery Following Birth Medication/Allergies Tests/Procedures Medical Conditions Developmental History

Pregnancy Proceeded Delivery Proceeded

Length of Pregnancy Delivery Was

Prenatal Care Visits Child's length of hospital stay

Pregnancy Complications

☐ Ectopic ☐ Positive for strep B

☐ Gestational diabetes ☐ Pre-eclampsia

☐ Multiple births ☐ Premature labor

☐ Polyhydramnios ☐ Substance exposure

☐ Positive for cytomegalovirus "CMV" ☐ Toxemia

☐ Positive for herpes ☐ Other: please specify

☐ Positive for HIV ☐

Delivery Complications

☐ Abruptio placenta ☐ Transverse presentation

☐ Breech presentation ☐ Prolapsed cord

☐ Low birth weight ☐ Use of forceps

☐ Negative vacuum ☐ Uterine rupture

☐ Non-progressive/lung/unproductive labor ☐ Umbilical cord around the neck

☐ Occiput posterior position (face up) ☐ Other: Please specify

☐ Placenta previa ☐

☐ Premature rupture of membranes ☐

Birth Information

Mother's Age at Time of Birth years

Birth Hospital

Needed to be Transferred to Another Hospital ☐ Yes ☐ No

Transfer Hospital

Please add any other comments regarding pregnancy or birth:

Multiple Child Pregnancies

Number of live births: Number of still births:

Additional details of birth:

Pregnancy/Delivery

← Medical History: Please complete this History First

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Pregnancy / Delivery **Following Birth** Medication/Allergies Tests/Procedures Medical Conditions Developmental History

☐ Yes ☐ No

☐ Failure to thrive ☐ Neonatal hypoxia

☐ Hyperbilirubinemia ☐ Oxygen dependency

☐ Intrauterine growth retardation "IUGR" ☐ PDA

☐ Anemia of prematurity ☐ IVH Bleed Grade I ☐ Positive dependency

☐ Bronchopulmonary dysplasia "BPD" ☐ IVH Bleed Grade II ☐ Respiratory distress syndrome

☐ Cleft lip ☐ IVH Bleed Grade III ☐ Respiratory stridor

☐ Cleft palate ☐ IVH Bleed Grade IV ☐ Respiratory syncytial virus "RSV"

☐ Club foot ☐ Jaundice treated with photo-light therapy &/or bil-
rubin blanket ☐ Retinopathy of prematurity "ROP"

☐ Cytomegalovirus ☐ Thrombocytopenia (Low Platelet Count)

☐ ECMO ☐ Meconium aspiration ☐ Ventilator dependency

☐ Necrotizing enterocolitis "NEC" ☐ VP Shunt

Following Birth

← Medical History: Please complete this History First

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Pregnancy / Delivery Following Birth **Medication/Allergies** Tests/Procedures Medical Conditions Developmental History

Hearing Testing

Last Test Date

Results

Concerns

Vision Testing

Last Test Date

Results

Concerns

Medications/Allergies



Pediatric History: Tabs 4-6 (subtab 1)

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Pregnancy / Delivery Following Birth Medication/Allergies **Tests/Procedures** Medical Conditions Developmental History

Physicians				Surgeries/Procedures	
Name	Specialty	Reason	Date of last visit	Type of surgery	Date

Diagnostic Tests	
Date last performed	Details/results

Comments (5)

Tests/Procedures

← Medical History: Please complete this History First

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Pregnancy / Delivery Following Birth Medication/Allergies **Medical Conditions** Developmental History

Does the child have:

<input type="checkbox"/> Allergies	<input type="checkbox"/> Chronic Ear Infections	<input type="checkbox"/> Muscular Dystrophy	<input type="checkbox"/> Shunts
<input type="checkbox"/> Arteriovenous malformation "AVM"	<input type="checkbox"/> Celiac	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Torticollis
<input type="checkbox"/> Atoxic brain injury	<input type="checkbox"/> Constipation	<input type="checkbox"/> Perinatal/Lukomatosis	<input type="checkbox"/> Traumatic brain injury "TBI"
<input type="checkbox"/> Asthma/respiratory breathing problems	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Reflux	<input type="checkbox"/> Tube feeding
<input type="checkbox"/> Autism	<input type="checkbox"/> Down Syndrome	<input type="checkbox"/> Seizure Condition	<input type="checkbox"/> Tubes in ears
<input type="checkbox"/> Backless pump	<input type="checkbox"/> Hip subluxation	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Degrees? <input type="text"/>
<input type="checkbox"/> Cerebral Palsy "CP"	<input type="checkbox"/> Hydrocele	<input type="checkbox"/> Sleep disorder	<input type="checkbox"/> Vagal nerve stimulator
<input type="checkbox"/> Cerebral Vascular Accident "CVA"	<input type="checkbox"/> Laryngomalacia	<input type="checkbox"/> Sleep problems	

Comments (5)

Medical Conditions

← Medical History: Please complete this History First

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Pregnancy / Delivery Following Birth Medication/Allergies Tests/Procedures Medical Conditions **Developmental History**

Motor/Play Sensory/Social-Emotional Feeding Speech/Language Home Environment Equipment Therapy/School History

When did the child begin:

Bringing both hands to mouth	Began at age: <input type="text"/>
Buttoning participant	<input type="text"/>
Come to sitting from lying without assistance	<input type="text"/>
Crawling or crawling alone	<input type="text"/>
Fully toilet trained	<input type="text"/>
Grabbing a toy	<input type="text"/>
Holding head up alone	<input type="text"/>
Putting self to standing position	<input type="text"/>
Rolling over	<input type="text"/>
Self-bathing	<input type="text"/>
Self-dressing	<input type="text"/>
Sitting alone without support	<input type="text"/>
Standing unsupported	<input type="text"/>
Tying shoes	<input type="text"/>
Walking with support	<input type="text"/>
Walking unaided	<input type="text"/>
Zippering/unzipping jacket	<input type="text"/>

Is the child

☐ Right-handed ☐ Left-handed ☐ No hand preference

Are there concerns about handwriting? ☐ Yes ☐ No

Please describe:

Description of Child

<input type="checkbox"/> Active	<input type="checkbox"/> Motivated	<input type="checkbox"/> Curious
<input type="checkbox"/> Affectionate	<input type="checkbox"/> Passive	<input type="checkbox"/> Demanding
<input type="checkbox"/> Aggressive	<input type="checkbox"/> Persistent	<input type="checkbox"/> Difficult to Comfort
<input type="checkbox"/> Calm	<input type="checkbox"/> Playful	<input type="checkbox"/> Distractible
<input type="checkbox"/> Cautious	<input type="checkbox"/> Shy	<input type="checkbox"/> Other: Please specify
<input type="checkbox"/> Fearless	<input type="checkbox"/> Stubborn	
<input type="checkbox"/> Fussy	<input type="checkbox"/> Withdrawn	
<input type="checkbox"/> Insecure	<input type="checkbox"/> Fearful	

Comments/Concerns

Developmental History
Motor-Play



Pediatric History: Sub Tabs 2-4

← Medical History: Please complete this History First

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Pregnancy / Delivery Following Birth Medication/Allergies Tests/Procedures Medical Conditions **Developmental History**

Motor/Play Sensory/Social-Emotional **Feeding** Speech/Language Home Environment Equipment Therapy/School History

Sensory Processing/Regulation

Select all that Apply

- ☐ Avoids getting messy
- ☐ Seeks out (craves) touch or movement
- ☐ Stumbles or falls frequently
- ☐ Appears awkward or less coordinated
- ☐ Flaps hands
- ☐ Allows brushing of teeth
- ☐ Bangs on surface, bangs/kicks head
- ☐ Fatigues quickly
- ☐ Has self-abusive behaviors
- ☐ Resists certain tasks or environments
- ☐ Spins things or self
- ☐ Is sensitive to lights, sounds or noise
- ☐ Sleeps a lot
- ☐ Resists touch
- ☐ Walks on toes
- ☐ Lines up toys or objects
- ☐ Seeks out (craves) visually stimulating objects
- ☐ Seeks out (craves) stimulating sounds
- ☐ Resists certain movements (e.g. bouncing, swinging, upside down)

☐ Has difficulty figuring out how to move body or takes more time with movements

☐ Does not tolerate certain textures (e.g. clothing, surfaces, foods, toys, etc)

☐ Uses a lot of pressure when touching someone or holding object

☐ Has difficulty transitioning from one activity to another

☐ Has difficulty falling asleep

☐ Has difficulty remaining asleep through the night

☐ Appears lethargic/sleepy at the time

☐ Has poor sense of body in space, runs into things

☐ Seeks support for posture (e.g. leans on furniture, walls or people, holds head)

☐ Demonstrates stiff or rigid movement patterns

☐ Hyperfocused (on specific tasks, people, objects, etc.)

Other: Please describe

Social/Emotional Skills

Select all that Apply

- ☐ Is easily distracted
- ☐ Calms self easily
- ☐ Gets angry/frustrated easily
- ☐ Is aggressive towards others
- ☐ Prone to emotional outbursts
- ☐ Doesn't allow others to join in play
- ☒ Has difficulty making friends
- ☐ Plays with peers
- ☐ Only plays with adults
- ☐ Prefers to play alone
- ☐ Has difficulty with separations
- ☐ Has poor eye contact
- ☐ Other concerns:

Developmental History
Sensory/Social-Emotional

← Medical History: Please complete this History First

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Pregnancy / Delivery Following Birth Medication/Allergies Tests/Procedures Medical Conditions **Developmental History**

Motor/Play Sensory/Social-Emotional **Feeding** Speech/Language Home Environment Equipment Therapy/School History

Current feeding concerns

Describe Any Feeding Problems (S)

Food preferences are:

Food dislikes are:

When did the child begin:

Using a Bottle Stop Using a Bottle

Using a Pacifier Stop Using a Pacifier

Eating Baby Food Using Utensils to Eat

Eating Junior Food Holding Open Bottle/Cup

Eating Table Food Self-feeding

Drinking From a Cup

Drinking From a Sip Cup

Using a Straw

Breast Feeding

☐ Currently ☐ Weaned ☐ Never

Times per day:

At age:

Areas of Difficulty

- ☐ Chewing
- ☐ Communicating Needs
- ☐ Transitioning Between Foods
- ☐ Jaw Shifts/Slides/Juts
- ☐ Drooling
- ☐ Swallowing
- ☐ Understanding Words

Current feeding adaptations

- ☐ Thickened liquids
- ☐ Adapted Utensils
- ☐ Adapted Seating
- ☐ Calorie Supplements
- ☐ Tube Feeding

Please specify:

Details:

Details:

Details:

Amount: Times per day:

Developmental History
Feeding

← Medical History: Please complete this History First

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Pregnancy / Delivery Following Birth Medication/Allergies Tests/Procedures Medical Conditions **Developmental History**

Motor/Play Sensory/Social-Emotional **Feeding** **Speech/Language** Home Environment Equipment Therapy/School History

Communication Skills

Does the child:

Have speech that is understood by most people? ☒ Yes ☐ No

Respond correctly to yes/no questions? ☐ Yes ☐ No

Follow simple instructions? ☐ Yes ☐ No

Respond when name is called? ☐ Yes ☐ No

Stutter? ☐ Yes ☐ No

Recognize objects, people, and places? ☐ Yes ☐ No

When did the child begin:

Bubbling Putting 2 words together

Saying first words Using short sentences

Naming familiar objects

First Words

Is an augmentative communication device used?

The child's primary method of communication is: Details:

Verbal Communication

Select the primary methods of verbal communication used:

- ☐ None
- ☐ 2 word phrases
- ☐ Vocalizations
- ☐ Complete sentences
- ☐ Single word phrases

Non-Verbal communication

Select the primary methods of non-verbal communication used:

- ☐ Facial expressions
- ☐ Gestures
- ☐ Body Language
- ☐ Pointing
- ☐ Manual Sign Language
- ☐ Eye Gaze

Communication concerns:

Developmental History
Speech-Language



Pediatric History: Sub Tabs 4-7

← Medical History: Please complete this History First

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Pregnancy / Delivery Following Birth Medication/Allergies Tests/Procedures Medical Conditions **Developmental History**

Motor/Play Sensory/Social-Emotional Feeding Speech/Language **Home Environment** Equipment Therapy/School History

Child lives with

Select all that apply:

☐ Birth Mother ☐ Adoptive Mother

☐ Birth Father ☐ Adoptive Father

☐ Step-mother

☐ Step-father

☐ Grandmother

☐ Grandfather

☐ Siblings Please list sibling ages: _____

☐ Other relative Please specify: _____

☐ Legal guardian Please specify: _____

Comments/Other Details:

Adoption

Age of child at adoption: _____

Please provide additional details of adoption (e.g. country, child's prior living situation, etc.):

Type of home

☐ Single Level Home ☐ Assisted Living Facility

☐ 2 Level Home ☐ Skilled Nursing Facility

☐ Ground Floor Apartment ☐ Group Home

☐ Upper Level Apartment ☐ Other: _____

Accessibility

☐ Stairs to get into Home How Many? _____

Handrail? ☐ _____

☐ Ramp to get into Home

☐ Stairs in Home How Many? _____

Handrail? ☐ _____

☐ Bathroom on Main Level ☐ Bedroom on Main Level

☐ Bathroom on Upper Level ☐ Bedroom on Upper Level

Comments _____

Developmental History
Home Environment

← Medical History: Please complete this History First

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Pregnancy / Delivery Following Birth Medication/Allergies Tests/Procedures Medical Conditions **Developmental History**

Motor/Play Sensory/Social-Emotional Feeding Speech/Language **Equipment** Therapy/School History

Equipment

Please select all that apply:

☐ Braces

☐ Walker

☐ Stander

☐ Manual Wheelchair

☐ Power Wheelchair

☐ Hooyer Lift

☐ Weighted Vest

☐ Hand Splint(s)

☐ Track System

☐ Other: _____

Approx. age of equipment _____

Details _____

Used at Home ☐

Used at School/Day Care ☐

Do you currently perform a home program with the child? (e.g. stretching, strengthening activities, brushing, etc) ☐ Yes ☐ No

If yes, please describe what you do:

Is the child involved in any community groups or sports activities? ☐ Yes ☐ No

If yes, please provide more details:

Developmental History
Equipment

← Medical History: Please complete this History First

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Pregnancy / Delivery Following Birth Medication/Allergies Tests/Procedures Medical Conditions **Developmental History**

Motor/Play Sensory/Social-Emotional Feeding Speech/Language **Home Environment** Equipment **Therapy/School History**

Grade in School _____ Where _____

Does your child have an I/SP? Yes ☐ No ☐

Does your child have an IEP from school? Yes ☐ No ☐

Has your child had a psychological or neuropsychological evaluation completed? Yes ☐ No ☐

Other Services

Type	Status	How Often?	Where?
<input type="checkbox"/> Assistive Technology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Audiology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Behavior Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Developmental Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> EI Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Intensive Ssl Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Vision Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Social Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Speech / Language Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Developmental Follow-up Clinic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments (s)

Developmental History
Therapy/School History

Last Step

Click to Save and Close History Once Complete