# Health Assessment/History

Today's Date: _____

Assessment information provided by: _____Relationship _____

Information obtained through (check one): ____initial assessment/interview ____ follow-up

| | | | |
|---|---|---|---|
| Name: | | Nickname: | DOB: |
| Parent(s)/guardian(s) | | | |
| Telephones | Cell: | Home: | Work: |
| Street, City, Zip: | | | |
| Additional Contact: | | | |
| Telephone | Cell: | Home: | Work: |
| Preferred Hospital: | | | |

Physicians

| | |
|---|---|
| Primary Care: | Phone: |
| | Fax: |
| Specialist: | Phone: |
| | Fax: |
| Specialist: | Phone: |
| | Fax: |
| Specialist: | Phone: |
| | Fax: |
| Specialist: | Phone: |
| | Fax: |

| | Most Recent Exam Date | History and treatment |
|---|---|---|
| Dentist: | | |
| Hearing: | | |
| Vision: | | |

Agencies and Case Managers

| | |
|---|---|
| | Phone: |
| | Fax: |
| | Phone: |
| | Fax: |

| Therapies | Contact | Schedule | Goals |
|---|---|---|---|
| Physical Therapy | Phone: | | |
| | Fax: | | |
| Occupational Therapy | Phone: | | |
| | Fax: | | |
| Speech Therapy | Phone: | | |
| | Fax: | | |
| Other | Phone: | | |
| | Fax: | | |

Medications:

| Medication | Dosage | Frequency | Route | At School | Emergency | Exp. Date |
|---|---|---|---|---|---|---|
| | | | | ☐ | ☐ | |
| | | | | ☐ | ☐ | |
| | | | | ☐ | ☐ | |
| | | | | ☐ | ☐ | |
| | | | | ☐ | ☐ | |
| | | | | ☐ | ☐ | |
| | | | | ☐ | ☐ | |

Birth History

| Birth weight: Gestation: | |
|---|---|
| Pregnancy/Delivery Complications: | NICU Length of Stay: |
| Other Information: | |

Brief Health History (Please use the Review of Systems for detail)

| |
|---|
| Medical Diagnosis: |
| Hospitalizations and Surgeries: (Include Dates and Reasons) |
| Does your child have a 504 plan for a health condition? |

Allergies No Needs:_____

| | |
|---|---|
| Medications: | Life Threatening?: Yes/No |
| Food: | Life Threatening?: Yes/No |
| Insect: | Life Threatening?: Yes/No |
| Environmental: | Life Threatening?: Yes/No |
| Action Plan: Yes/No | |
| Emergency Medication: Yes/No Name:<br><br>Expires: | |
| Food Intolerances/Special Diets: | |

REVIEW OF SYSTEMS

Respiratory No Needs:_____

| | | |
|---|---|---|
| History:<br><br>Asthma: □ Triggers:<br><br>Asthma Action Plan: _____ Days of School missed last school year:_____ | | |
| ER visits (Dates and reason): | Pulmonary Vest □ Frequency: | |
| Nebulizer □ Inhaler □ Frequency:<br>Spacer □ Prescriber's Authorization to Self Carry □ | Chest PT □ Frequency: | |
| Mechanical ventilation: Home □ School □ Sleep □ As needed per orders □ | | |
| Oxygen: Continuous □ Intermittent □ Oximetry □ Frequency: Parameters: | | |
| Route: Nasal Cannula □ Tracheotomy □ | Tank □ Liquid □ Concentrator □ | |
| CO2 monitor □ Frequency: Parameters: | | |
| Suctioning □ Catheter size: Frequency: | Trach size: | Cuffed □ |
| Other Information: | | |

Cardiac: No Needs:_____

| | | |
|---|---|---|
| History: | | |
| Hospitalizations and Surgeries (please Include Dates): | | |
| Restrictions: | Baseline Vtial Signs: | Fatigue? |

GastroIntestinal: No Needs:_____

| History: | Hospitalizations and Surgery (Include Dates): |
|---|---|
| | |

Nutrition and Feeding Safety No Needs:_____

| Oral feedings □ Special diet □ Texture:<br><br>G Tube □ Type_____ | Fluid consistency/restrictions: | |
|---|---|---|
| Food preferences/restrictions: | | |
| Tube feedings □ Bolus □ Pump □ | Frequency in hours<br>Amount: | Fundoplication? □ |
| Last swallow study: Videofluoroscopic □<br>Endo □ | Where?/results: | |
| Feeding clinic □ Who, how often? | Reflux □<br>Tx: | Ordering MD: |

Orthopedics/Motor Abilities and Mobility No Needs:_____

| Orthopedic History (including injuries and surgeries): |
|---|
| Ambulatory □ Independent □ Walker/gait trainer □<br>Special considerations: |
| Wheelchair: manual independent □ manual assist □ power □ Equipment provider: |
| Scoliosis □ Last x-ray/exam: Treatment: |
| Hips □ Last x-ray/exam: Treatment: |
| Details of mobility concerns, tone strength, endurance: |
| Orthotics □ Splints: Hand □ Knee □ Other □ |

Renal No Needs:_____

| History: | Surgeries (Please include dates): |
|---|---|
| | |

Elimination: No needs:_____

| History: | Toileting Needs:<br><br>Scheduled □ Prompted □<br>Diapered □ Other: |
|---|---|
| Bowel regime □<br>History of constipation □ | Management: |
| Urinary Catheterization Yes/No Catheter size: Frequency: Stoma? | |
| Menstruation □ Management: | |
| Other Information: | |

Neurological No Needs:_____

| Seizures □ | Type: | Shunt □ | Last exam: |
|---|---|---|---|
| Age of onset: Date of last event: Treatment: Diastat □ Oxygen □ Vagal Nerve Stim □ | | | |
| Episode description, triggers, history of status, post seizure activity, safety needs? | | | |
| Other Information: | | | |

Communication

| |
|---|
| Verbal □ Non-verbal □ Speech needs □ Hearing needs □ |
| Augmentative device □ Signs/gestures □ Expressions □ Cries/smiles □ No communication □ |
| Additional Information: |

Sleep

| |
|---|
| Total nighttime hrs: Stays asleep □ Requires Naps □ Fatigues during day □ Snores □ |
| Sleep study □ When/results: |

Other medical Information

| |
|---|
| History, diagnosis, treatments, etc.: |

Additional Information/Specific Cultural Beliefs

| |
|---|
| Awareness of Safety Issues/Behaviors/Awareness of pain/Soothers: |

Reviewed by RN: _____ Date: _____