REHAB RESOURCES OF SHEBOYGAN

Medial History **Name** _____

Birth History

Hospital _____ Obstetrician _____
Type of delivery _____ Complications _____
Birth Weight _____ Birth Length _____ Discharge Weight _____
Did baby have any problems at or immediately after birth?
List Age: Cooed or laughed ____Sat _____First Word ____ Held Head Up ____Walked_____Toilet Trained_____

Health History

Minor/Child's Physician _____ City/State _____ Phone _____
Date of last physical examination _____ Results _____

	YES	NO	
Is Minor/Child under care of physician now?	_____	_____	Medications _____
Receiving any medication or drugs?	_____	_____	_____
Has your child been hospitalized?	_____	_____	_____

Date Reason Hospital Allergies _____
_____ _____
_____ _____

HAS MINOR/CHILD HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING:

Yes	No		Yes	No		Yes	No		Yes	No	
		A.I.D.S/H.I.V.			Chicken Pox			Heart Problems			Rheumatic Fever
		Anemia			Constipation, Diarrhea			Hepatitis			Sinus Problems
		Asthma			Convulsions			Kidney Disease			Speech Problems
		Bed Wetting			Diabetes			Lead Poisoning			Thyroid Disease
		Birth Defects			Drug/Alcohol Abuse			Liver Disease			Tuberculosis
		Bladder Problems			Ear Infections			Measles			Urinary Disease
		Bleeding, excessive			Epilepsy			Mononucleosis			Vision Problems
		Cancer			Fainting			Mumps			Worms
		Cerebral Palsy			Hearing Problems			Pneumonia			Other

Immunization

Check whether or not your minor/child has been given the following immunizations. If yes, please fill in the date given.

Yes	No	Date		Yes	No	Date		Yes	No	Date	
			DPT Series of 3 shots				Polio by Mouth, Series 3				Diptheria Tetanus
			DPT Booster Shots				Measles Vaccine				Hepatitis B
			Polio Shots Series of 3				Mumps Vaccine				Tuberculin Test
			Polio Booster Shots				Rubella Vaccine	+/-			Result

Release and Assignment

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my minor/child's medical status.
Private Insurance? Yes No If Yes, _____
Name of Insurance company (ies)

I hereby authorize RRI to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____
Signature of Parent/ Guardian Date