Pediatric Physical Medicine & Rehabilitation Follow-Up

Name: _____________________________________________   Patient MRN: _____________________
Today’s Date: ________________________________

Current Therapies: Please list                                GMFCS: ___________________________

<table>
<thead>
<tr>
<th>Therapy</th>
<th>Frequency</th>
<th>Duration</th>
<th>Location (school/IEP/private)</th>
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</thead>
<tbody>
<tr>
<td>Physical Therapy</td>
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<tr>
<td>Occupational Therapy</td>
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<td>Speech Therapy</td>
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<td>Aqua Therapy</td>
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<td>Hippo Therapy</td>
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<tr>
<td>Other</td>
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Current Medications: Please list

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<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
<th>Route</th>
<th>Frequency</th>
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Do you use any of the following? Check all that apply

- [ ] Braces
- [ ] Splints
- [ ] Stander
- [ ] Walker
- [ ] Wheelchair

Please describe:
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Please list any medical problems, surgeries, recent illnesses, and injuries since the last appointment:
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
Review of Systems: Please circle ALL that apply

Fevers/chills/unintentional weight change/chronic pain/infections? YES/ NO
Difficulty seeing/hearing/double vision? YES/ NO
Difficulty swallowing/headaches/seizures/falls/drooling/choking? YES/ NO
Chest pain/palpitations/fainting/sweating? YES/ NO
Shortness of breath/wheezing/cough/snoring? YES/ NO
Nausea/vomiting/diarrhea/reflux/loss of control of stools/constipation? YES/ NO
Loss of control of urine/urinary frequency/urgency/retention? YES/ NO
Dizziness/weakness/numbness/tingling? YES/ NO
Depressed mood/sleep problems/anxiety/agitation/mood swings? YES/ NO
Pain/spasticity/dystonia/scoliosis/abnormal gait/joint swelling? YES/ NO
Rash/sores/eczema/itching/ecchymosis/non healing wounds? YES/NO
Cancer/sickle cell/anemia/bleeding disorder? YES/NO
Diabetes/thyroid disease/lupus/excessive fatigue? YES/NO