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## **Pediatric Physical Medicine & Rehabilitation Follow-Up**

| Name:            |   |            | Patient MRN:         |                             |
|------------------|---|------------|----------------------|-----------------------------|
|                  |   |            |                      |                             |
| se list          |   |            | GMFCS:               |                             |
| Frequency        |   | Duration   | Loc                  | cation (school/IEP/private) |
|                  |   |            |                      |                             |
|                  |   |            |                      |                             |
|                  |   |            |                      |                             |
|                  |   |            |                      |                             |
|                  |   |            |                      |                             |
|                  |   |            |                      |                             |
|                  |   |            |                      |                             |
| Dose             |   | Route      |                      | Frequency                   |
|                  |   |            |                      |                             |
|                  |   |            |                      |                             |
|                  |   |            |                      |                             |
|                  |   |            |                      |                             |
| llowing? Check a | all that app                                  | ly         |                      |                             |
| ☐ Splints        | ☐ Stan  | der        | □ Walker             | ☐ Wheelchair                |
|                  |   |            |                      |                             |
|                  |   |            |                      |                             |
| oroblems, surger | ies, recent                                   | illnesses, | and injuries si      | nce the last appointment:   |
|                  |   |            |                      |                             |
|                  | Frequency lease list  Dose  Illowing? Check a | Frequency  | Frequency   Duration | Frequency   Duration   Loc  |

## Review of Systems: Please circle ALL that apply

| Fevers/chills/unintentional weight change/chronic pain/infections?      | YES/ NO |
|---|---------|
| Difficulty seeing/hearing/double vision?                                |         |
| 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  |
|   |         |