Rainbow Kids
ACHIEVEMENT CENTER

30252 Tomas Suite 100, Rancho Santa Margarita, CA 92688 Ph: 949-459-1658 Fax: 949-459-1667

PATIENT INFORMATION

Date: _____ Families Email Address: _____

***** All reports and correspondence will be sent via email and will not be shared with other agencies.**

Patient's Name: _____ Sex: _____
Last First Middle Initial

Address: _____
Street City Zip Code

Date of Birth: _____ Phone: _____

Primary Insured on Insurance Policy _____

DOB _____ SSI# _____

Primary language spoken in the home _____

Current Reason for Referral _____

PARENT INFORMATION

Father's Name: _____ Father's Employer: _____

Home address: _____
Street City Zip Code

Home Phone #: _____ Work Phone #: _____

Cell Phone # _____ Email Address: _____

Mother's Name: _____ Mother's Employer: _____

Home address: _____
Street City Zip Code

Home Phone #: _____ Work Phone #: _____

Cell Phone # _____ Email Address: _____

Legal Custody/Guardianship: N/A Shared Other

Names and ages of brothers and sisters:

_____ _____

Name Age Name Age

_____ _____

Name Age Name Age

PHYSICIAN

Pediatrician: _____

Name Address Phone

Date of last visit: _____

Other Physicians involved in your child's health care _____ Yes _____ No

_____

Name Specialty Phone

BIRTH HISTORY

Birth Weight: _____

Gestation/delivery: _____ normal _____ abnormal: _____

Complications during Pregnancy _____ Yes _____ No

Full Term Pregnancy _____ Yes _____ No

How many weeks pregnant _____ NICU Stay: _____ Yes _____ No

Birth Weight: _____ Vaginal Delivery _____ C-Section _____

Gestation/delivery: _____ normal _____ abnormal: _____

Medical Treatment at birth: _____ _No _____ Yes: _____

Medications at birth: _____ No _____ Yes: _____

Birth History: (Please explain in detail any marked significance in your child's birth history not mentioned above)

_____
_____
_____
_____

MEDICAL HISTORY

Immunizations Current: Yes _____ No _____ If no, why? _____

Immunization History:

VACCINE	DATE EACH DOSE WAS GIVEN				
	1ST	2ND	3RD	4TH	5TH
Polio (OPV or IPV)	/ /	/ /	/ /	/ /	/ /
DTP/DtaP/DT/TD (Diptheria, tetanus and [acellular] pertussis or tetanus, and diphtheria only)	/ /	/ /	/ /	/ /	/ /
MMR (Measles, mumps, rubella)	/ /	/ /			
(Required for child care only) **HIB Meningitis** (Haemophilus B)	/ /	/ /	/ /	/ /	
Hepatitis B	/ /	/ /	/ /		
Hepatitis A	/ /	/ /	/ /		
Varicella (Chickenpox)	/ /	/ /			

SCREENING OF TB RISK FACTORS

- ❑ Risk factors not present: TB skin test not required.
- ❑ Risk factors present: Mantoux TB skin test performed (unless previous positive skin test documented).

_____ Communicable TB disease not present.

Previous Therapy/Intervention _____ No _____ Yes: _____
(when and what)

Is there a history of major illnesses or hospitalizations _____ No _____ Yes

_____
_____
_____

Other Pertinent Medical History:

_____
_____
_____

Is your child currently diagnosed with a seizure disorder? _____
If so, what type of seizures? _____
How often do they occur? _____
Please specify seizure – emergency plan: _____
_____
_____

Number of Ear Infections _____

Is there a family history of delay? _____ No _____ Yes
_____
_____

Does your child have a specific medical and or developmental diagnosis? ____ No _____ Yes
If so, please explain:

_____
_____

Date of Onset or Diagnosis: _____ Who diagnosed: _____

Current Medications:

_____
_____

Allergies: _____

Hearing test: Yes ____ No ____ Results: _____

Vision Test: Yes ____ No ____ Results: _____

Any Imaging Studies _____ Yes _____ No

_____MRI _____ CT _____ X-Ray

DEVELOPMENTAL HISTORY

Developmental Milestones — Age Occurred:

- Sat without support _____
- Crawled on hands and knees _____
- Stand _____
- Walk _____
- Talk _____

Language Development:

- Cooing _____
- Babbling _____
- Jargon or true words _____
- Phrases/sentences _____
- Conversational speech _____

What is your child able to eat at this time: _____ Limited Diet _____ Special Diet

_____

_____

Does your child demonstrate any of the following difficulties with feeding/oral motor skills?

- ☐ Overstuffing mouth with food
- ☐ Gag/vomit during feeding
- ☐ Frequently drools
- ☐ Food preferences/selective
- ☐ Avoids face washing
- ☐ Avoids tooth brushing
- ☐ Difficulties with chewing skills
- ☐ Spillage of food/drink from their mouth
- ☐ Difficulties with cup and /or straw
- ☐ Food texture preferences

If Yes, Please explain:

_____

_____

_____

Does your child have a history of Reflux _____ Yes _____ No

Was your child breast fed _____ Yes _____ No

Do you have any feeding concerns: _____ Yes _____ No

If Yes, Please explain:

_____
_____
_____

Self-Help Skills

	Independent	Needs Assistance
Socks		
Shoes		
Shirt		
Pants		
Tying shoes		
Brushing teeth		
Toileting		
Using a spoon/fork		
Zipper		
Buttons		

Does your child get easily u8pset with being moved from one place to the next?
_____Yes _____ No

Does/did your child tolerate tummy time? _____ Yes _____ No

Does your child have regular exposure with crawling or walking up and down stairs?
_____Yes _____ No

Does/did your child walk on his/her toes? _____ Yes _____ No

Does your child fall frequently by tripping or bumping into things? _____ Yes _____ No

Does your child have special equipment – GTT, wheelchair, AFO's, etc.?

_____
_____
_____

How does your child communicate wants/needs (words, gestures, sentences)?

_____
_____
_____

Does your child respond when you call his/her name? _____ Yes _____ No

CURRENT INFORMATION

Child's overall health _____ Good _____ Fair _____ Poor

Current Weight _____ Current Height _____

Does your child sleep well? _____ Yes _____ No

_____
_____
_____

Does/did your child ever have any problems with feeding, reflux, or breathing?
_____ Yes _____ No

_____
_____
_____

Does your child participate in age appropriate movement activities? (Rolling over, jumping, swinging, riding a bike, etc.) _____ Yes _____ No

_____
_____
_____

Does your child use eye contact and gestures when needing assistance or attempting to communicate? _____ Yes _____ No

_____
_____
_____

Describe any difficulties you have with your child's behavior?

_____
_____
_____

What are your current concerns and what do you expect from therapy/program?

_____
_____
_____

EDUCATIONAL HISTORY

Is your child presently in school? _____ No _____ Yes

Name of school: _____

Teacher's name: _____

Grade: _____ Is he/she having any educational difficulties? _____

Does your child currently have an IEP? _____ No _____ Yes

Is your child receiving any special help? If so, please list specific disciplines and schedule.

_____

_____

_____

EMERGENCY INFORMATION

In case of emergency, please specify 3 people we may contact:

(1) _____
Name Phone # Relationship

(2) _____
Name Phone # Relationship

(3) _____
Name Phone # Relationship

REFERRAL INFORMATION

Who referred you to Rainbow Kids Achievement Center?

( ) Doctor
( ) School District
( ) Regional Center of Orange County
( ) Other

RELEASE OF INFORMATION

I hereby authorize Rainbow Kids Achievement Center to obtain and use all medical, social, and education reports pertaining to my child, _____ as necessary to evaluate and/or treat my child. This authorization shall remain in effect until my child is formally discharged from treatment or until I have submitted a written statement to Rainbow Kids Achievement Center, which terminates this authorization.

Parent's Signature: _____ Date: _____