CHILDREN'S REHABILITATION SERVICE
MEDICAL HISTORY INFORMATION FORM

STATE OF ALABAMA
DEPARTMENT OF REHABILITATION SERVICES

CLIENT INFORMATION

SSN: _______-______-______

Last Name: ________________________ First: _____________________ Middle: ________________ Suffix: _______

Referring Diagnosis: ____ Date: ________________________

Referred by: ____ Phone number: (____) ______-________

Address: ____

Previous Treatment/History: ____

____

____

____

Current Medications and Dosage: ____

BIRTH HISTORY

Length of pregnancy: ____ Birthweight: _________________________

Complications:

during pregnancy ____

during labor/delivery ____

after birth ____

Place of delivery: ____

Length of stay in nursery: ____

My child has/had:

____ measles
____ mumps
____ chicken pox
____ scarlet fever
____ diabetes
____ herpes
____ asthma
____ CMV
____ sickle cell
____ genetic testing
____ heart problems
____ ear infections
____ hearing problems
____ vision problems
____ eating problems
____ learning problems
____ sleeping problems
____ others _________________
____
____

Allergies

☐ None known

List allergies (including medications): ____

____

Pertinent Family Health History (Mother's and father's family, if known)

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____

Other family members known to CRS: ____

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