Patient History Form / Questionnaire

The following information is a true and accurate account of_____
_ medical, physical and mental condition. I am providing_____ with a copy for records and/or insurance purposes only. All information is confidential and may not be released to other individuals by _____ without my written consent.

_____
Parent / Guardian Signature

The following information is a true and accurate account of this patient's medical, physical and mental condition.

_____
Physician / Therapist / RN Signature

Date_____

Patient Name_____ Date of Birth_____
Patient Height_____ Patient Weight_____
Address_____ Phone_____
City_____ State_____ Zip Code_____

Patient Diagnosis _____
_____
_____
_____
_____
_____
_____
_____

MEDICAL INFORMATION

Does this patient have seizures? _____
If yes, what type? _____
_____
_____
How often do they occur? _____
What seizure medication is he/she taking? _____
_____
Do the seizures compromise his/her respiratory status? _____
If yes, in what way? _____
_____
_____
In what way do the seizures cause potential injury? _____
_____
_____

Does he/she require special positioning not feasible with a standard bed? _____
Does he/she require frequent and/or rapid changes in position? _____
Does the need for special positioning relate to respiratory, GI, cardiac, and/or orthopedic problems?
_____
What respiratory problems exist that require special positioning? _____
_____
_____
Does he/she require any routine treatments for chronic respiratory problems? _____
If yes, what type? _____
Does he/she ever require prompt intervention for a medical crisis? _____ If yes, please explain: _____
_____
_____
_____
_____
Has he/she required hospitalization related to these respiratory problems? _____
If yes, please explain: _____
_____
_____
_____
What GI or swallowing disorders exist that require special positioning? _____
_____
_____
What GI medication is he/she presently taking? _____
Has he/she had any medical complications as a result of this disorder? _____
If yes, please explain: _____
_____
_____
Has he/she had surgery for a GI disorder? _____
If yes, please explain type and result: _____
_____
_____
Does he/she require special feedings? _____
If yes, what type and why? _____
What cardiac disorders exist that require special positioning? _____
_____
_____
What cardiac medication is he/she taking? _____
Have there been any surgical interventions? _____
If yes, what type? _____

BEHAVIORAL INFORMATION

Is he/she self abusive? _____
If yes, explain _____

_____

_____

What type of injuries has he/she sustained? _____

_____

_____

_____

Has he/she ever required medical attention for a self inflicted injury? _____

If yes, explain: _____

_____

_____

_____

What medications have been tried to reduce this behavior? _____

What behavioral modifications have been tried to reduce this behavior? _____

_____

_____

_____

Does he/she tolerate confined areas? _____

Does he/she prefer confined areas? _____

If yes, explain: _____

_____

_____

_____

Does he/she have any sleep disturbances? _____

What is the average amount of sleep per night?_____

Have any and if so, what medications have been tried to induce sleep? _____

_____

_____

What behavioral modifications has been tried to improve sleep habits? _____

_____

_____

Does he/she attempt to wander during the night? _____

What potential problems exist because of wandering? _____

_____

_____

Does he/she recognize danger or show fear? _____

Does he/she continue with inappropriate behaviors despite danger? _____

If yes, please describe specific instances: _____

_____

_____

_____

Has he/she been found in any dangerous situations or sustained any minor injuries during night time wandering attempts? _____

If yes, explain: _____

_____

_____

_____

Has he/she required medical attention for any injuries sustained during the night time wandering attempts? _____

_____

Does loss of sleep/rest affect his/her health and/or behavior? _____

If yes, explain: _____

_____

_____

_____

Does he/she exhibit PICA behavior (tried to eat/chew inedible objects)? _____

If yes, explain: _____

_____

_____

_____

Does he/she have any injuries resulting from this PICA behavior? _____

If yes, explain: _____

_____

_____

_____

PHYSICAL INFORMATION

Does he/she have abnormal muscle tone? _____

If yes, describe: _____

_____

_____

Does he/she have proper coordination and protective responses? _____

If no, explain: _____

_____

_____

Can he/she sit independently? _____

Can he/she pull to tall kneel? _____

Can he/she pull to stand? _____

Can he/she safely resume to sitting from a standing position? _____

If no, what occurs? _____

_____

_____

Can he/she walk? _____

If non ambulatory, is he/she mobile by other means (crawl, roll, scoot, etc)? _____

If yes, explain: _____

_____

Is he/she ataxic or lose balance easily? _____

Has he/she sustained any minor injuries during falls from this poor balance or control? _____

If yes, explain: _____

_____

_____

Has he/she sustained any injuries from poor balance or control that have required medical attention? _____

If yes, explain: _____

_____

_____

_____

FAMILY SUPPORT

Who are his/her primary caregivers? _____

_____

How many caregivers are in the home during the night time? _____

Do the primary caregivers have outside jobs? Who? _____

_____

_____

How many other children/dependents are cared for in the home? _____

Does he/she receive any skilled nursing care? _____

How many hours per week or month? _____

Does he/she receive any aide or respite care? _____

How many hours per week or month? _____

Does he/she attend day care, school, or any other program? _____

If yes, what type? _____

_____

BED OPTIONS

What is his/her current bed? _____

Why is this bed no longer appropriate? _____

_____

_____

Has he/she been endangered or injured because of present bed? _____

If yes, explain: _____

_____

_____

_____

Have you considered/tried a standard bed with side rails? _____

Is this type of bed appropriate or inappropriate? _____

What features of the current bed in use cause concern or problems? _____

_____

_____

_____

_____

Have you considered/tried a hospital crib? _____

Is that type of bed appropriate or inappropriate? _____

What features of this bed cause concern or problems? _____

_____

_____

_____

Will bumper pads for standard beds or cribs provide adequate protection? _____

If no, explain: _____

_____

_____

Have you considered/tried a mattress on the floor? _____

Is this option appropriate or inappropriate? _____

What problems or concerns are the regarding this bed option? _____

_____

_____

Have you considered/tried chemical or tie down restraints? _____

Are those appropriate or inappropriate? _____

What problems or concerns are there regarding their use? _____

_____

_____

Have you considered a SleepSafe Bed for him/her? _____

Is this an appropriate option to meet the needs of the patient? _____

What are the specific features of a Sleep Safe Bed that make it most appropriate for this patient?

_____

_____

_____

_____

Of all available bed options, what is your request/recommendation? _____

_____

_____

Additional Comments: