Baseline Data

Normal Vital Signs

Pulse rate _____ Site best taken _____
BP _____ Site best taken _____
Temp _____ Site best taken _____
Resp rate/minute _____
Oxygen saturation _____
Skin color _____
Best blood draw site _____
Pupils (normal, dilated, constricted, equal) _____

Systems	OK	Problem	Comments/Description
CNS/Sensory	❑	❑	
Heart/Blood (include recent blood counts)	❑	❑	
Gastrointestinal	❑	❑	
Respiratory (describe breath sounds)	❑	❑	
Gentourinary	❑	❑	
Muscoskeletal	❑	❑	
Baseline Xray findings	❑	❑	
Developmental	❑	❑	
Other:	❑	❑	
	❑	❑	
	❑	❑	
	❑	❑	
	❑	❑	
	❑	❑	
	❑	❑	

Normal Status

Areas to Check	Normal Status is	N/A
Rash		
Drainage		
Nose		
Eyes		
Ears		
Fontanels		
Seizure activity		
Verbal skills		
Activity level		
Vent dependent/trach/C-pap		
Motor skills		
Upper body extremities		
Lower body extremities		
Stool		
Urine		
Feeding behaviors/Source		
Ostomy sites		
Behavior/attitude		
Sleeping patterns		
Blood sugars		
Communication		
Other:		

Child's Name _____ **Date of Birth** / /

Date Last Revised: _____

Allergies

Food/Drug/Other	Reaction	What To Do (Give EpiPen®, Meds, Call 911, etc.)	Date Noted

Child's Name _____ **Date of Birth** / /

Date Last Revised: _____

All About Me

My Name _____

My Nickname _____

I live at ❑ Home ❑ School ❑ Foster Home ❑ Hospital ❑ Other

Family member names (first name/last name/relationship)

_____

_____

_____

_____

_____

_____

Close friends, babysitters, neighbors (first name/last name/relationship)

_____

_____

_____

_____

_____

_____

Pets (Type/Name) _____

_____

_____

_____

Favorite Foods _____

Least Favorite Foods _____

Favorite Songs/Music _____

Favorite Toys/Games _____

Favorite Hobbies/Other Things _____

Favorite TV Shows/Computer Games _____

Favorite Friends _____

Favorite People _____

I like to do these things in my free time _____

_____

_____

I usually go to bed at _____

Before bed, I usually _____

_____

_____

Things I need help with (i.e. brushing teeth, washing, dressing, etc.)

_____

_____

_____

_____

Things I can do myself _____

_____

_____

_____

_____

_____

Other _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Child's Name _____ **Date of Birth** / /

Date Last Revised: _____

Preferences

Communication

Can she/he be understood by others? _____

Preferred language/methods of communication:

❏ Talk ❏ Sign ❏ TTY ❏ Picture board ❏ Computer keyboard ❏ Gesture/facial

❏ Other _____

Are there specific words/gestures that have special meaning?

_____

_____

_____

_____

_____

_____

_____

Name of interpreter if required: _____

Is your child deaf/hearing impaired? _____

Is your child legally blind/visually impaired? _____

Child's Ethnicity

Family's preferred language: _____

Family's religious beliefs/customs that may affect treatment:

_____

_____

_____

_____

_____

_____

Notes

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Personal Care and Hygiene

Independent

Things that I can do independently (i.e. brushing teeth)

Assistance

Things that I need assistance with

Other helpful information (i.e. shoe and clothing size, menstrual cycle, etc.)