



Physical, Occupational & Speech Therapy

Medical History Form

Client: _____

DOB: _____

Name of Person Completing this Form: _____

Relationship: _____

Does client have any current limitations:

Medical History:

Does client have any allergies? Yes No If yes, please list: _____

Does client have a diagnosis? Yes No If yes, please list: _____

Is the client currently on any medications? Yes No If yes, please list: _____

Has the client had Head injuries/Concussions, fractures or stitches? Yes No If yes, please explain: -

Has the client ever been hospitalized? Yes No If yes, please explain and give age at each hospitalization: _____

Has the client ever had a seizure? Yes No If yes, Date of first seizure: _____

Since the first seizure how many seizures has your child had? _____

Any feeding problems or nutritional concerns? _____

Please check all that apply:

- | | | | | |
|--|---|---|----------------------------------|-----------------------------------|
| <input type="checkbox"/> Trach | <input type="checkbox"/> Allergies (list below) | <input type="checkbox"/> Hearing aids | <input type="checkbox"/> Glasses | <input type="checkbox"/> C-line |
| <input type="checkbox"/> Latex sensitivity | <input type="checkbox"/> Hearing difficulty | <input type="checkbox"/> Vision problem | <input type="checkbox"/> G-tube | <input type="checkbox"/> Seizures |

Comments: _____

Medical Personnel: Is the client being seen by any doctor/medical personnel other than a pediatrician/family practitioner? (Please check below)

- | | | |
|--|---|---|
| <input type="checkbox"/> Neurosurgeon | <input type="checkbox"/> Dentist | <input type="checkbox"/> Neurologist |
| <input type="checkbox"/> Psychologist/Psychiatrist | <input type="checkbox"/> Rheumatologist Ear Nose & Throat | |
| <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Speech Therapist |
| <input type="checkbox"/> Other: _____ | | |

Therapy: Please list the start day and current frequency for the following if applicable:

	<i>Pervious</i>	<i>Current</i>	<i>Frequency</i>
Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	_____ x per week/month
Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>	_____ x per week/month
Speech Therapy	<input type="checkbox"/>	<input type="checkbox"/>	_____ x per week/month
Counseling	<input type="checkbox"/>	<input type="checkbox"/>	_____ x per week/month
Other: _____			

Special Services: Does the client receive any special services? Yes No If yes, please list below:

School: Does client attend school? Yes No If yes, please fill out information below

What school does client attend? _____

- Regular Education Special Education

What grade is client in? _____

Does client receive any services in school? Yes No If yes, please list below

- Occupational Therapy Speech Therapy
 Physical Therapy Other: _____

Does client have any difficulty performing age appropriate activities listed below? (Check all that apply)

Thank you for taking the time to fill out this questionnaire. This information will help us to become more familiar with the client so that we can provide the best service possible to you and your child.

Signature

Date