Medical History Information Form

Please answer the questions as completely as possible. If you need help filling out this form, we would be happy to assist you.

Patient Name________________________________ Birth Date: __________________ Today's Date: _________________

What is the reason for your Child's Visit Today:

☐ Relief from Pain ☐ Improve Head Shape ☐ Improve Handwriting
☐ Manage Tone ☐ Improve Head Position ☐ Improve Fine Motor
☐ Strengthen Core ☐ Strengthen Muscles ☐ Address Behavior Needs
☐ Improve Gross Motor ☐ Improve Walking ☐ Improve Communication
☐ Improve Flexibility ☐ Address Sensory Needs ☐ Improve Feeding
☐ Other: ____

What would you like your child to accomplish in therapy?

Pain: Do you feel that your child experiences pain? (Does your child demonstrate any signs of pain during rest or with movement?) ☐ yes ☐ no

Location of pain: ☐ Head ☐ Neck ☐ Shoulder ☐ Back ☐ Elbow ☐ Wrist ☐ Hand ☐ Hip ☐ Knee ☐ Ankle ☐ Foot
☐ Other: ____

Rate the Pain (0=no pain, 10=worst pain) _____

Current Medications (Please list type, dose and purpose of medication): ☐ NA

Allergies: ☐ NA

Food		Environmental		Medications
☐ Eggs	☐ Shell Fish	☐ Animal	☐ Mold and Mildew	☐ Penicillin
☐ Dairy	☐ Strawberries	☐ Dust	☐ Cockroaches	☐ Sulfa
☐ Gluten	☐ Tree Nuts	☐ Smoke	☐ Dust Mites	☐ Insulin
☐ Fish	☐ Peanuts	☐ Latex	☐ Adhesive	☐ Iodine
☐ Soy	☐ Other:_____________	☐ Seasonal	☐ Other:_____________	☐ Other:_____________

Precautions (Please list any restrictions your child has including medical, emotional, physical restrictions): ☐ None
☐ Weight bearing ☐ Isolation ☐ Diagnosis Specific ☐ Spinal Precautions ☐ Feeding ☐ Cardiac
☐ Physician Directed ☐ Other: ____
Explain Precautions:____

Preferred Language: ☐ English ☐ American Sign Language ☐ Arabic ☐ Chinese **Interpreter Needed**: ☐ yes ☐ no
☐ Nepali ☐ Somali ☐ Spanish ☐ Mandarin ☐ Other:___________________________

Do you have any additional needs? ☐ Nutrition Counseling ☐ Cultural/Religious Counseling ☐ Support Groups ☐ None

Does patient have a completed Advanced Directive (Document concerning medical procedures at end of life)? ☐ No ☐ Yes

Are you ready and able to learn a home exercise program? ☐ Yes ☐ No
Would you prefer instructions: ☐ Verbally ☐ As Written Documentation ☐ Through Demonstration

Parent Signature: ____ **Date:** ______________________

Therapist Signature: ____ **Date:** ______________________

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