Total Pediatric Therapy MEDICAL HISTORY

Patient Name_____ Age_____

Was your child born full-term? ☐ Yes ☐ No If no, what gestational age?_____

Did your child require any advanced medical care upon birth? ☐ Yes ☐ No

If yes, please describe:

_____

_____

List any complications during pregnancy: _____

_____

Type of Injury / Condition _____

Onset / Injury Date_____

Next Doctor's Appointment? _____

Describe any previous treatments for this condition_____

Have you received physical therapy, occupational or speech/feeding treatments this year? ☐ Yes ☐ No

If so, please explain_____

Please mark the skills which your child has accomplished and at what age:

☐ Rolling _____ ☐ Pull to Stand_____ ☐ Jumping_____
☐ Crawling_____ ☐ Walking_____ ☐ Riding a tricycle_____
☐ Sitting_____ ☐ Running_____

Has your child ever had any of the following?

☐ Surgeries
☐ Sprains / Strains
☐ Heart Problems
☐ Circulation Problems / Clots
☐ Easy Bruising / Bleeding
☐ Indigestion / Heartburn / Reflux
☐ Loss of Consciousness
☐ Diabetes
☐ Cancer
☐ Asthma / Breathing Problems
☐ Leg / Ankle Swelling
☐ Fainting
☐ Fractures
☐ Blood Pressure Problems
☐ Motor Vehicle Accident
☐ Lung Disease
☐ Urinary Problems
☐ Allergies / Skin Sensitivity

List current medications_____

What do you hope to get out of physical therapy treatments/ what **goals** do you have?

_____

Patient or Personal Representative Signature **Date**