TOTAL Pediatric THERAPY

Physical • Occupational • Speech

PHYSICAL THERAPY PATIENT HISTORY

MEDICAL HISTORY

Child's Full Name :

Child's Age : **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 :

Date of Onset : **Next Doctor's Appt. :**

Describe any previous treatments for this condition:

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

If yes, please explain:

Has your child ever had any of the following:

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

List current medications:

SKILLS ATTAINED

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

- ☐ Rolling
- ☐ Crawling
- ☐ Sitting
- ☐ Pull to Stand
- ☐ Walking
- ☐ Running
- ☐ Jumping
- ☐ Riding a Tricycle

GOALS

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

Patient or Legal Guardian Signature **Date:**