Medical History

Please complete the following questionnaire so that I can gather more information about your child as part of the evaluation. Please do not worry if you can't answer all the questions.
Thank you!

Child's Name: ____

Sex: Male ☐ Female ☐ Date of Birth: ___/___/_____

Name of Person Completing the Questionnaire: ___________________________________

Relationship to the child? ____

Parents/Guardian's Names: ____

Who does the child live with? ____

Pregnancy: Normal ☐ Difficult ☐

Age of mother during pregnancy: ___

Term: Full ☐ Term ☐ Pre-mature ☐ (# of Weeks gestation) ___

Delivery: Caesarian ☐ Vaginal ☐

Birth Weight: ___

Hospital of delivery ____

Please describe any complications during pregnancy of during birth:

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Has your child received therapy previously? If so, please indicate dates as well as type (clinic, school, etc.)

____

Describe child's current health: ____

Height: ____Weight: ____

Last Physician's Examination: ____

Pediatrician: ____

Please list all surgeries, hospitalizations, and major illness since birth:

Date: ___/___/_____Reason. ____

Date: ___/___/_____Reason, ____

Date: ___/___/_____Reason ____

Please list any medical condition your child has been diagnosed with: ______________________

____

Please list current medications: ____

____

Amount. ____________Frequency ____

Please list any known allergies: ____

Does your child have any assistive devices?

Please list: ____

Has your child had:

Formal hearing evaluation? Yes, ☐ No ☐

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If yes, results? ____

____

Formal vision evaluation? Yes ☐ No ☐

If yes, results? ____

____

Age your child first:

Rolled over ☐ sat ☐ crawled ☐ walked ☐ finger fed ☐ used a spoon ☐

First words ☐ Gained bladder control: day ☐ night ☐

Gained bowel control: day ☐ night ☐

Describe sleep habits: ____

____

Describe eating /drinking habits: ____

____

Describe dressing and hygiene skills: ____

____

Describe Communication Skills: ____

____

Describe Developmental Concerns: ____

____

List activities that your child enjoys: ____

____

Please use this space to clarify any of the above or list any other concerns you wish to address:

What is your goal for therapy?

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