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 treatment this year? Yes / No

Have you received occupational therapy treatment this year? Yes / No

Have you received speech therapy treatment this year? Yes / No

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

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

Has your child ever had any of the following?

- ☐ Surgeries
- ☐ Sprains / Strains
- ☐ Heart Problems
- ☐ Circulation Problems / Clots
- ☐ Easy Bruising / Bleeding
- ☐ Indigestion / Heartburn / Refulx
- ☐ Loss of Consciousness
- ☐ Diabetes
- ☐ Cancer
- ☐ Asthma / Breathing Problems
- ☐ Leg / Ankle Swelling
- ☐ Fainting
- ☐ Fractures
- ☐ Blood Pressure Problems
- ☐ Motor Vehicle Accident
- ☐ Lung Disease
- ☐ Urinary Problems / Infections
- ☐ Allergies / Skin Sensitivity
- ☐ Any previous injury that may affect current care _____

Explain & give approximate dates for any items indicated above_____

_____

Is the patient currently taking medications? Yes / No Name or Type of Medication _____

_____

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

_____

Is there anything else you would like to include or ask your physical therapist? _____

_____

_____ _____

Patient or Personal Representative Signature **Date**