



Physical, Occupational & Speech Therapy  
Fitness & Weight Management

## Medical History From

Childs Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Name of Person Completing This From: \_\_\_\_\_ Relationship: \_\_\_\_\_

### Developmental History:

Please indicate at what age your child achieved the following milestones:

If you don't recall, then please  if it was completed within normal time frames.

If your child has not yet achieved write "N/A."

_____ Rolled over	_____ Babbled	_____ Sat alone
_____ Said first word	_____ Crawled	_____ Drank from a cup
_____ Pulled to stand	_____ Used spoon	_____ Stood alone
_____ Toilet trained	_____ Walked alone	_____ Dressed self
_____ Button & zipper clothes	_____ Tie shoe laces	_____ Two word phrases
_____ Sentences	_____ Alternate feet while ascending stairs	

Does your child have any current physical limitations?: \_\_\_\_\_

\_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

### Medical History:

Does your child have any allergies? \_\_\_ Yes \_\_\_ No If Yes, please list: \_\_\_\_\_

\_\_\_\_\_

Does your child have a diagnosis? \_\_\_ Yes \_\_\_ No If Yes, please list: \_\_\_\_\_

\_\_\_\_\_

Is your child currently on any medications? \_\_\_ Yes \_\_\_ No If Yes, please list: \_\_\_\_\_

\_\_\_\_\_

Has your child had Head injuries/Concussions, fractures or Stitches? \_\_\_ Yes \_\_\_ No If Yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Has your child ever been hospitalized? \_\_\_ Yes \_\_\_ No If Yes, please explain and give age at each hospitalization: \_\_\_\_\_

\_\_\_\_\_

Has your child ever had a seizure? \_\_\_ Yes \_\_\_ No If Yes, Date of first seizure: \_\_\_\_\_

Since the first seizure how many seizures has your child had? \_\_\_\_\_

Check any special equipment your child uses: Splints \_\_\_ Braces \_\_\_ Adaptive utensils \_\_\_ Other \_\_\_\_\_

Any feeding problems or nutritional concerns? \_\_\_\_\_

Please check all that apply to your child:

Trach  Allergies (list below)  Hearing aids  Wears glasses  C-Line  
 Latex sensitivity  Hearing difficulty  Vision problem  G-tube  Seizures

Comments: \_\_\_\_\_

**Medical Personnel:** Is your child being seen by any doctor/medical personnel other than a pediatrician/family practitioner? (please  below)

Neurosurgeon  Dentist  Neurologist  
 Psychologist/Psychiatrist  Rheumatologist Ear Nose & Throat  
 Occupational therapist  Physical Therapist  Speech Therapist  
 Other \_\_\_\_\_

**Therapy:** Please list the start date and current frequency for the following if applicable:

Physical Therapy: \_\_\_\_\_ times per week Occupational Therapy: \_\_\_\_\_ times per week

Speech Therapy: \_\_\_\_\_ times per week Counseling: \_\_\_\_\_ times per month

**Equipment:** Does your child utilize any of the following specialized equipment? (Check all that apply)

Bath  Chair  Cane  Crutches  Glasses  Hearing Aid  
 Stander Walker  Specialized Stroller  Wheelchair: Manual or Power

Other: \_\_\_\_\_

**Special Services:** Does your child receive any special services (If yes, please list below).  Yes  No

**School:** Does your child attend school? (If yes, please answer questions below)  Yes  No

What school does your child attend? \_\_\_\_\_ Regular Education Special Education

What grade is your child in? \_\_\_\_\_

Does your child receive any services in school? (If yes, please list below). Yes No

Occupational Therapy Physical Therapy Speech Therapy Other: \_\_\_\_\_

Does your child have any difficulty performing age appropriate activities listed below? (Check all that apply)

Bathing Reaching  Toileting  Climbing Stairs Running Using Utensils  
 Communicating  Sitting  Walking  Dressing Sleeping  
 Feeding Themselves  Social Interacting

Thank you for taking the time to fill out this questionnaire. This information will help us to become more familiar with your child so that we can provide the best service possible to you and your child.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date