PATIENT MEDICAL HISTORY

Today's Date _______________

Patient Name: _________________________________ D.O.B. ___________ Sex: M F

Diagnosis: ____

Person completing this form: ___________________________ Relationship to patient: _____________

Please describe your concerns regarding your child: ____

____

Birth History: □ Full Term □ Premature ____ wks Birth Weight: _________
□ Caesarian □ Vertex (head first) □ Breech

How long was your child in the hospital following birth? ________________________________

Please describe any complications with the pregnancy or delivery? _______________________

____

Developmental History: Please list in months when the following first occurred:

Activity	**Age (months)**	**Activity**	**Age(months)**
Held up head		Babble	
Roll		First Words	
Sat Alone		Drink from a cup	
Crawl		Chew meat	
Pull Up		Finger Food	
Stand Alone		Spoon feed self	
Walk		Potty trained	
Jump		Scribble	
Ride Tricycle			
Skip			
Run			

Medical History: Please list other physicians and specialists who provide care to your child:

Name	Specialty	Phone Number

Children's Therapy Source
14M Worlds Fair Drive, Somerset, New Jersey 08873
Phone 732-356-5363 ● Fax 732-356-5364
www.ChildrensTherapySource.com

Check any of the following that apply to your child:

__ Chronic illness
__ Recurrent hospitalizations
__ Sleeping problems
__ Seizures
__ Meningitis
__ Headaches
__ Chronic infections
__ Sight problems
__ Feeding problems
__ Diabetes
__ Chicken pox
__ Reflux
__ Cancer
__ Hearing problems
__ Physical injuries
__ Heart defect
__ High fever
__ Asthma

Please list any other illnesses (other than typical childhood illnesses), hospitalizations, surgeries, and diagnostic testing that your child has had:
____

____

____

Current Medications:

Name	Dosage	Frequency	Reason for this Medication

Any Known Allergies?: ____

What is your child's current weight? __________ pounds height? ___________

Vision tested? □ yes □ no If yes, date of last vision test: ________________________________

Vision tested by: _____________________ Results of vision test: ____________________________

Hearing tested? □ yes □ no If yes, date of last hearing test: _________________________

Hearing tested by: ___________________ Results of hearing test: ____________________________

FEEDING:
Bottle _______ Breast________ Combination _____________
Would you describe your child as a good eater or picky eater? Yes / No
Check any of the following that you have observed:
__ coughing or choking on certain foods (list) ____
__ putting too much food in mouth at one time
__ food falling out of mouth
__ difficulty chewing meats
__ unable to drink without spilling
__ history of aspiration (date of most recent swallow study ______________)
__ food aversion / refusal

SOCIAL/EMOTIONAL HISTORY:

Who lives in your home? ____

Describe your child's daily/weekly schedule: ____

What motivates your child? ____

What upsets your child? ____

Favorite activities/toys: ____

EDUCATION INFORMATION:

Is your child currently enrolled in school? □ yes □ no

If yes, where and which days attended? ____

Does your child receive services through school? □ yes □ no

If yes, what services? ____

Does your child have a current Individualized Education Plan (IEP) or an Individualized Family Service Plan (IFSP)? □ yes □ no

Please include any additional information about your child that you would like to share: _____________

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AUTHORIZATION and CONSENT for EVALUATION and TREATMENT:

____I hereby give Children's Therapy Source consent to evaluate and treat my child and I understand that there will be written, oral, and electronic communication between care providers/physicians, insurance companies, and Children's Therapy Source staff.

Photo Release:

____ I give permission for photos/video of my child to be used for treatment, documentation, and/or education.

____I give my permission for photos/video of my child to be used for advertising, brochure, and/or webspace.

Text/Email Communication:

______I give my permission for ____text _____email correspondence with my child healthcare providers, care team, and parents/guardians regarding treatment, documentation, and home program. I understand that messages sent via email or text may be intercepted by a third party.