PROrthotics & OT, LLC

HISTORY FORM - Infant

Today's Date: ___________________________

Completed by _____________________________________ Relationship to patient: ____

Child's Name: ____ Birthdate: _________________________ Age: _________________

Primary Physician ____ Phone ____

Does your child have any allergies? Please list: ____

What other specialists has your child seen (Orthopedics, Neurology, Cardiology, etc) ______________________________________

____

Medical Diagnosis(es): ____

Birth Information Gestational age (length of pregnancy) ___________weeks Birth weight ________________ ICU? _________________

Type of Delivery: Vaginal _____ C-section _____ Breech _____ Forceps ______ Other ______

Complications following delivery: Jaundice ______ Breathing ______ Heart problems _____ Seizures ______ Other ___________

Child's Medical History: Please list all illness, conditions child has experienced: ____

____

Surgical procedures: Ear tubes _______ Removed? ______ Trach ______ G-Tube ______ Shunt ______ Heart Surgery ______ TAL _______

Orthopedic surgery/type/date: ____

Please list any current medications and reason for use: ____

What are your concerns related to the prescribed device?____

Therapies: List type, location and duration: ____

Is there anything else we should know? ____

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