Clinic: Grayslake, IL
Aquatic: Pleasant Prairie, WI/Grayslake ,IL
Home/Daycare/ School
847-548-3458 Clinic
847-548-3459 Fax
www.therapeuticlinks.com

Medical History

Child's Name:_____ DOB:_____
Person completing this form and relationship to child:_____
Please complete this form to the best of your knowledge. If you do not remember, please state unknown.

Birth History:

Was your child adopted? YES/ NO
(If yes and birth history is unknown, please skip to current medical information on page 2)

Prenatal care received: YES / NO / UNKNOWN

Was your child full term? YES / NO.
If no, what was the length of pregnancy in weeks?_____

Pregnancy proceeded WITH / WITHOUT complications. If complications were present, please list:_____
_____
_____

Birth hospital:_____

Delivery proceeded WITH / WITHOUT complications
If complications, please list additional care that was needed:_____
_____
_____
_____

Delivery was VAGINAL / C-SECTION / EMERGENCY C-SECTION

Birth weight:_____ Birth height:_____

Was the baby discharged home with mom? YES / NO
If no: please explain:_____

Did the baby need to be transferred to another hospital for additional care? YES / NO

Additional details of birth (please explain): (In NICU, jaundice, etc):_____
_____

Was your child Breastfed? YES/ NO
If yes- for how long? _____

Current Medical Information:

Does your child have a specific diagnosis and/or suspected diagnosis? YES / NO
If yes, please explain:_____
_____

Who is the doctor that provided this diagnosis?_____
Is the child still under this doctor's care? YES / NO

Current Medications: (Please list dosage and frequency):_____
_____
_____
_____

Current vitamins, supplements, herbs, and/or homeopathic remedies? Please list dose, frequency and usage:_____
_____
_____

Please list ALL allergies and sensitivities:_____
_____
_____

Does your child require an EPI-Pen YES / NO
If yes, please be sure to complete our EPI-PEN form.

Has your child's *HEARING* ever been tested? YES / NO
If so, what were the results within normal limits? YES /NO
Does your child have PE tubes? YES / NO / PREVIOUSLY
Does your child have frequent ear infections? YES / NO / Previously
If yes, please explain:_____
_____

Do you have any concerns regarding your child's hearing? YES / NO

Has your child's *VISION* ever been tested? YES / NO
If so, what were the results within normal limits? YES /NO
If no, please explain:_____
Does your child wear glasses? YES / NO
If yes, do they need to wear them full time? Please explain: _____
_____
Do you have any concerns regarding your child's vision? YES / NO

Please list *ALL on-going specialists* and services your child *currently receives* including frequency of visits (outside of school): (may include but not limited to: neurologist, cardiologist, psychologist, chiropractor, homeopathic practitioner, physical therapy, etc)

_____
_____
_____
_____

Has your child ever been hospitalized or had any major illness? YES / NO
If yes, please explain:_____
_____

Has your child received any medical tests such as MRI, EEG, etc that may be pertinent to his/her treatment here? YES / NO
If yes, please explain:_____
_____
_____

Has your child undergone any surgeries? YES / NO
If yes, please explain:_____
_____

Developmental History:

Did your child meet all developmental milestones within normal limits? If your child is an infant/toddler, is your child meeting current developmental milestones?
(Sitting up at 6-9 mos, rolling 4-6 months, walking approximately 12 mos, etc?)
YES / NO / UNSURE
If no or unsure on normal limits, Please explain:_____
_____
_____

What hand is used most often for utensil use?
RIGHT / LEFT / UNDETERMINED

If age appropriate, do you have concerns regarding handwriting?
YES / NO / PREVIOUSLY
If yes, please explain:_____

Description of child:
Please describe your child's strengths: _____
_____
_____

What are your child's favorite toys and activities? _____

Child's Demeanor:
(Please **check** ✔all that apply)
☐ Active
☐ Affectionate
☐ Aggressive
☐ Calm
☐ Cautious
☐ Curious
☐ Demanding
☐ Difficult to comfort
☐ Distractible
☐ Fearful
☐ Fearless
☐ Fussy
☐ Insecure
☐ Motivated
☐ Passive
☐ Persistent
☐ Playful
☐ Shy
☐ Stubborn
☐ Withdrawn
☐ Other: Please explain:_____
_____
_____

Child's Sensory Processing 'Behaviors':

(Please **check** ✔all that apply; Put **P** if previously seen)

☐ Avoids getting messy
☐ Seeks out (craves) touch/ tactile stimulation
☐ Seeks out movement
☐ Stumbles or falls frequently
☐ Appears awkward or less coordinated
☐ Flaps arms
☐ Does not allow brushing of teeth
☐ chews/sucks on non-food items frequently
☐ Lines toys up/ limited play skills
☐ Bangs head, hit surfaces, hits others frequently
☐ Fatigues quickly
☐ Sedentary
☐ Resists certain environments
☐ Spins things or self frequently
☐ Has self-abusive behaviors
☐ Is sensitive to noises or sounds
☐ Is sensitive to lights
☐ Sleeps more than typical
☐ Resists touch or being held/hugged
☐ Seeks intense hugs/deep pressure from others
☐ Walks on toes
☐ Seeks out visually-stimulating objects
☐ Seeks out stimulating sounds
☐ Enjoys music
☐ Resists certain movements. Please list: _____
☐ Has difficulty figuring out how to move his/her body
☐ Does not tolerate certain textures. Please list:_____
☐ Has difficulty with transitions
☐ Has difficulty falling asleep
☐ Has difficulty staying asleep
☐ Has poor sense of body in space(leans on furniture or people and/or runs into things)
☐ Demonstrates rigid or still movement patterns
☐ Hyper-focused on specific items, tasks, people, toys, etc
☐ Other: Please explain:_____

_____

_____

Child's Social Emotional Skills:

(Please **check** ✔all that apply)

☐ Is easily distracted
☐ Calms self easily
☐ Gets angry or frustrated easily
☐ Is aggressive towards others
☐ Prone to emotional outbursts
☐ Doesn't allow others to join in play
☐ Plays easily with peers
☐ Makes friends easily
☐ Does not have very many known friends
☐ Only likes to play with adults or older peers
☐ Prefers to play alone
☐ Has difficulty with separations
☐ Poor eye contact
☐ Difficulty with communication of wants and needs
☐ Other: Please explain:_____

Does your child have any feeding problems or difficulties: YES / NO
If yes, please explain:_____
Is your child a picky eater? YES / NO
If yes, please list *prefered* foods:_____
_____
Please list *Non-prefered* foods:_____
_____

Do you have any concerns regarding Speech? YES / NO
If yes, please explain:_____
_____
Does your child receive private speech services? YES / NO / PREVIOUSLY

Child's Home Environment, Work and Leisure:

Who does your child live with? _____
_____

Please list any extracurricular activities your child participates in:_____
_____
_____

Does your child have or are you in need of any adapted equipment and/or assistive devices/ technology? YES / NO / UNSURE
If yes, please explain:_____
_____

If age appropriate, does your child participate in chores around the house? YES / NO
If yes, please explain:_____
_____

If age appropriate does your child perform activities of daily living with minimal to no assistance?
(These activities include but not limited to: waking up in the morning, getting dressed/undressed, brushing teeth, taking a bath/shower, dressing for weather, feeding self and/or preparing simple meals etc)
YES / NO
If no, please explain areas of difficulty:_____
_____

Educational history:

Name of school:
Grade:

Does your child have an IEP YES / NO

Does your child have a 504 Plan YES / NO

Please list all special education services is your child receiving at school: _____
_____
_____

Would you like Therapeutic Links to communicate with your child's school? YES / NO
If yes, please provide contact information and please make sure your school has an authorization to speak to us. (Please provide us any school IEP/ 504 plans in order to assist with our communication with the school as well as please complete our consent release)

Any additional comments and/or information, please list and explain below: