Date:

Children’s Therapy Place Inc.
Client Medical/History Information

Child’s Name:		DOB:
Diagnosis:		
Siblings and/or others living in the home:		
School:	Grade:	Teacher:
Does your child receive other therapy services at another clinic? If so, what type of therapy and where?		

Pregnancy/Birth:
Gestational age: ___________ Child’s birth weight: ____________
Type of delivery: Vaginal Breech Cesarean
Were instruments used? Yes No Did baby stay in NICU? Yes No
Hospital where baby was born: _________________________ or birth outside of hospital

Were any of the following conditions present at birth? (Circle)

Paralysis	Did not cry	HIV positive	Jaundice
Fractures	Cord around neck	Blue color	Birth defects
Needed oxygen	Breathing problems	Bruised head	Multiple births
Seizures	Low pulse rate	Unresponsive	

Other: ____

Are any of the following conditions present in your child’s immediate family?

Condition	Who	Comments
Autism		
ADD/ ADHD		
Learning disabilities		
Speech/language disorder		
Hearing impairments		
Vision impairments		
Mental retardation		
Birth defects		
Mental health issues		
Epilepsy (seizures)		
Cerebral palsy		

Medical History:

____
____
____
____
____
____
____
____

When did you first notice that your child had delays?
____

At what age did your child sit?_____________, Say first word?_________________
Say two words?__________________, Was potty trained? ____________________
At what age did your child babble? _________________, Walk? _______________

Please list any hospitalizations, operations and/or accidents/injuries in your child's medical history and dates they occurred.

____
____
____
____
____

Does your child have frequent illnesses or infections? Describe:
____

Does your child experience any of the following?

Vision problems: (squinting, crossed eyes, getting very close to TV, books, etc., rapid eye movements, wears glasses, other)

____
____

Hearing problems: (chronic ear infections, pain in ear, discharge from ear, tubes in ears, hearing aid, other)

____
____

Special medical needs/devices: (AFO's, back brace, wheel chair, other) ______________
____

Has your child ever had a convulsion or seizure? Yes No age: ____________________

Please list any medications your child is currently taking, dosages and reason for taking:

____
____
____
____

Allergies:

Please list any allergies your child has (food/medication/etc): ______________________
____

Are there any diet/food restrictions: ____

Additional information:
How many hours of sleep per night? ___________________

Does child take a nap? Yes No How long? _______

Does your child enjoy being hugged? Yes No Cuddled? Yes No

Does child worry a lot or seem to be afraid? Yes No
Describe: ____

Have there been any major changes in the child's life in the past year? Yes No
Describe: ____

What are your primary needs/concerns for your child at this time?
____
____
____

What are your long term goals for your child?
____
____

What special interests or activities does your child have? What motivates them?
____
____

Thank you for taking the time to fill out this information!
When Completed Please Return This Form To:
6855 W Fairview Ave, Boise ID 83704
(208) 323-8888 Fax (208) 323-8889