Date:

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

Child's Name:		DOB:	Diagnosis:
Address:		Medicaid #:	SSN:
Mother:	Home phone:	Cell:	Work phone:
Email:			
Father:	Home phone:	Cell:	Work phone:
Address/Email (if different from above):			
Siblings and/or others living in the home:			
School:	Grade:	Teacher/Case Manager:	
Physician:		Ph:	
Dr. Leavell or other psychologist/specialist(s):			
Immunizations current? Yes No *please bring a copy for our records*			
Speech, Occupational and/or Physical therapist(s):			
Service coordinator:	Agency:	Ph:	

Pregnancy/Birth:
Did mother visit the physician more than 5 times during pregnancy? Yes No
Did mother begin physician care after 28 weeks (7 months) of pregnancy? Yes No
Mother's age at time of birth: _____
Gestational age: _____ Child's birth weight: _____ Length: _____
Type of delivery: Vaginal Breech Cesarean Was labor induced? Yes No
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: _____

Please check any of the following conditions that existed during pregnancy and indicate which month the problem occurred:

Anemia _____
Elevated blood pressure _____
Toxemia _____
Heart problems _____
RH blood sensitization _____
Bleeding _____
Seizures _____
Medications _____
Drugs/alcohol _____
Pesticide exposure _____
X-ray exposure _____
Injury _____
Chronic kidney disease _____
Virus or serious illness _____
Problems with placenta _____
Diabetes _____
Problems with amniotic fluids _____
Smoking (# smoked per day) _____

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		
Abuse		
Alcoholism		
Chemical dependency		
Cancer		
Heart disease		
Diabetes		

Has the client or family participated in any of the following programs? (Circle)

Personal Care Services
Child protection
High risk infant care
High risk maternal care
Immunizations
Medicaid
Well Child Clinic
Head Start
Indian Health Services
EPSDT health check
Social security
Katie Beckett program
WIC Nutrition program
Food stamps
Financial assistance
Maternity clinic
Family planning clinic
Children's special health program

All children learn to do things at different times. Think back to when your child started doing these different things and indicate the age, or check the "not applicable" box if your child is not doing the activity.

Activity	Age	N/A	Activity	Age	N/A
Respond to loud sounds			Use 2-3 word sentences		
Grasp rattle			Recognize familiar pictures		
Lift head and chest while on tummy			Feed self with spoon		
Smile			Walk up steps alternating feet		
Reach for and pick up objects			Ride a tricycle		
Roll from stomach to back			Put on shoes		
Transfer objects from one hand to other			Use 3-5 word sentences		
Sit without support			Use the toilet		
Pull to standing position			Dress and undress with little help		
Crawl on hands and knees			Wash hands alone		
Drink from a cup			Give first and last names		
Wave bye-bye			Catch a large ball		
Feed self finger food			Bathe self		
Walk without help			Dress alone		
Use 8-10 words that are understood					

When did you first notice that your child had delays?

_____

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

_____

_____

Please list any serious accidents or injuries 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:
_____
_____
_____
_____

Last visit to the dentist: _____
Last visit to the physician: _____

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

Are there any diet/food restrictions: _____

Approximately how many hours per night does your child sleep? _____

Does child take a nap? Yes No What time of day? _____ How long? _____

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

Have there been any legal/custody concerns involving your child? Yes No
Describe: _____

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?

_____
_____
_____
_____

How many hours per week of therapy would you like your child to access during therapy? (Maximum of 22 hours per week)

_____

Which days of the week and hours of the day would you like therapy? (Please check days you are requesting and start and end times for each day)

- **Monday** _____
- **Tuesday** _____
- **Wednesday** _____
- **Thursday** _____
- **Friday** _____
- **Saturday** _____

Please list any other information that would help us provide the best possible services for your child.

_____
_____
_____
_____
_____
_____
_____

Thank you for taking the time to fill out this information!
When Completed Please Return This Form To:
6855 W Fairview Ave Ste 120, Boise ID 83704
(208) 323-8888 Fax (208) 323-8889