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

Child's Name:		DOB:
Diagnosis:		
Parents/Caregivers, siblings, and/or others living in the home (please list name, relation, and age):		
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		
Intellectual Disability		

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? _____, Crawl? _____, Walk? _____, Was potty trained? _____
At what age did your child babble? _____, Say first word? _____, Say two words? _____,

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!