CANDIDATE NAME:

PAST MEDICAL HISTORY FORM:

Completed By:

DATE:

Candidate's Current Weight: lbs. Current Height:

BIRTH HISTORY:

Date of Birth:

Hospital: CITY/STATE:

Birth Weight: lbs. oz. Height:

How many weeks Gestation? Apgar Score: /

Delivery: (Check all that apply): ☐ Vaginal ☐ C-Section ☐ Labor Induced ☐ Breech
☐ Twins or More ☐ Forceps/Vacuum Used

Maternal Complications at Delivery: ☐ NO ☐ YES

Explain:

Did baby have any complications at delivery? ☐ No ☐ Yes

Explain:

Did Baby require NICU Care? ☐ No ☐ Yes How Long?

Explain:

Vision Tested? ☐ **No** ☐ **Yes** **Date:**

Results: ☐ **Normal** ☐ **Concerns:**

Hearing Tested? ☐ **No** ☐ **Yes** **Date:**

Results: ☐ **Normal** ☐ **Concerns:**

CANDIDATE NAME:

ALLERGIES:

MEDICATIONS:

HOSPITALIZATIONS/SURGERIES: (use back if more space needed)

	Date:	**Doctor:**

PLEASE CHECK OFF AND EXPLAIN ANY OF THE FOLLOWING CONDITIONS YOUR CHILD HAS/HAS HAD:

- ☐ High Blood Pressure
- ☐ Respiratory Infection:
- ☐ Frequent Colds ☐ Ear Infection
- ☐ Tracheal Tube ☐ G-Tube ☐ Ear-Tubes
- ☐ GI Problems/Disorder:
- ☐ Shunt/Hydrocephalus ☐ Failure to Thrive
- ☐ Seizures ☐ Epilepsy
- ☐ Diabetes: ☐ Type 1 ☐ Type 2
- ☐ Heart Condition:
- ☐ Kidney Problems:
- ☐ Cancer:
- ☐ Muscular Stiffness ☐ Floppy ☐ Trembling
- ☐ Encephalitis ☐ Meningitis
- ☐ Head Injury ☐ Accident/Fall
- ☐ Skin Rash/Condition:
- ☐ Difficulty Eating:
- ☐ Attention Disorders ☐ Emotional Disorders
- ☐ Chronic Illness:
- ☐ Other:
- ☐ Electrolyte Abnormalities:
- ☐ Metabolic Disease/Disorder:
- ☐ Infectious Disease:
- ☐ Rheumatoid Disorder
- ☐ Pulmonary Disease:
- ☐ Osteoporosis
- ☐ Bone Fractures:
- ☐ Decreased Bone Density
- ☐ Hip Subluxation/Dislocation
- ☐ Scoliosis ☐ Osteogenesis Imperfecta
- ☐ Mylogenic Conditions:
- ☐ Muscular Disorder:
- ☐ Congenital Disorders:
- ☐ Reaction to Immunizations:
- ☐ Anemia
- ☐ Difficulty Sleeping:
- ☐ Speech/Language Disorders:
- ☐ Other:
- ☐ Other:

CANDIDATE NAME:

PHYSICIANS YOUR CHILD IS CURRENTLY FOLLOWING:

Specialty:	Doctor's Name:	Phone #:	Date of Last Visit:	Follow-Up Frequency:
Pediatrician:				
Neurologist:				
Orthopedist:				
Genetecist:				
Pulmonologist:				
Cardiologist:				

Has your Child previously received any type of therapeutic services? ☐ No ☐ Yes

Please indicate below:

	Location:	Clinician:	Frequency/Duration:
Physical Therapy:			
Occupational:			
Speech Therapy:			
Behavioral:			
Chiropractor:			
Other:			

CURRENT EQUIPMENT:

	Date Received:	Vendor:	Phone#:
WHEELCHAIR:			
STROLLER:			
STANDER:			
BATH CHAIR:			
Bike/Tricycle:			
Other:			

CANDIDATE NAME:

CURRENT ORTHOSIS:

	Date Received:	Orthotist:	Phone#:
AFO/DAFO:			
Benik Vest:			
Theratogs:			

Other:

SOCIAL HISTORY:

School: Grade:

Type of Classroom: IEP: ☐ NO ☐ YES

Services Received:

Transportation To School: ☐ Public School Bus ☐ Private School Bus ☐ Parent/Guardian

Is Walker/Gait Trainer used at School?

How many hours does child use wheelchair at school?

Home Setting: ☐ 1-Story ☐ 2-Story ☐ Apartment Building ☐ Elevator

# of steps to enter home:

Does Candidate Use a Walker at Home? ☐ NO ☐ YES Model:

What distance can they walk at home?

How many hours does child use wheelchair at home?

Primary Language Spoken in the Home:

Please explain any special circumstances we need to be aware of:

Thank you so much for your time in completing this form!