In-Sync & Social

Medical History Form

Child's Name:	Date of Birth:
Name of Person Completing Form:	Relationship:

PRESENT MEDICAL INFORMATION

Please complete this section completely

Current Diagnosis:		
Who Referred You to Therapy?		
Present Therapy Concerns:		
Other Medical Concerns/Precautions:		
General Health of Your Child:	☐ Excellent ☐ Good	☐ Fair ☐ Poor
Present Medications:		
Does your child have a history of any seizures?	☐ yes	☐ no
If yes, please explain.		
Has your child ever had any previous therapies?	☐ yes	☐ no
If yes, please explain when, where, and what type.		
Has your child had formal vision testing?	☐ yes	☐ no
If yes, where and what were the results?		
Does your child wear glasses?	☐ yes	☐ no
Is your child presently followed for vision care?	☐ yes	☐ no
Has your child had formal hearing testing?	☐ yes	☐ no
If yes, where and what were the results?		
Does your child have any adaptive/medical equipment?	☐ yes	☐ no
If yes, please explain.		
Does your child follow any special diet?	☐ yes	☐ no
If yes, please explain.		
Does your child have any allergies?	☐ yes	☐ no
If yes, please explain.		

PRESENT ABILITIES/STRENGTHS

Please complete this section completely

Describe the following about your child:
Ability to communicate wants/needs:
Attention span:
Ability to follow directions:
How does your child handle stress? Please describe their coping skills.
Ability to be redirected:
Strength and Balance:
Hand dominance/preference:
Writing skills:
Visual skills:

INJURY/SURGERY INFORMATION

Please complete this section if therapy is related to an injury or surgical procedure

Date of Injury:

Please explain the injury and how it occurred?

Was surgery performed due to this injury? ☐ no ☐ yes Date of surgery:___________

Where was surgery performed?

Length of hospital stay?

Please explain the details of the surgery.

Did you have any therapy concerns for your child prior to this event? ☐ yes ☐ no

If yes, please explain.

Does your child have any medical or movement precautions because of this? ☐ yes ☐ no

If yes, please explain.

Has your child received previous therapy for this injury/surgery? ☐ yes ☐ no

If yes, please explain

BIRTH HISTORY

Please skip this section if your child is not here for a birth or developmental problem

Was pregnancy full term? ☐ yes ☐ no **Gestational Weeks Completed:_______**weeks

Type of Delivery: (check all that apply): ☐ vaginal ☐ caesarian ☐ breech ☐ forceps ☐ suction

Length of Hospital Stay:

Was the baby at any time in distress? ☐ yes ☐ no

Birthweight: _____pounds _____ounces

Please explain any complications the mother and/or baby had before, during, or after the birth:

Was there any type of diagnosis or medical concern about the baby after birth?

Please describe any family history of developmental or learning problems:

DEVELOPMENTAL HISTORY

Please skip this section if your child is not here for a birth or developmental problem

At what approximate age did your child reach the following developmental milestones (if applicable)?

__________roll over	__________say first word	__________feed self
__________sit alone	__________use 2 word sentences	__________dress self
__________creep on all fours	__________speak clearly	__________use crayons
__________walk independently	__________drink from a cup	__________cut with scissors

Has your child been evaluated by a Developmental Pediatrician? ☐ yes ☐ no

If yes, who and where?

Does your child have a current IFSP/IEP? ☐ yes ☐ no

If yes, please bring provide Theraplay with a copy.

THERAPY GOALS

Please describe what your goals for therapy are. What do you hope therapy will accomplish?