FYZICAL®
Therapy & Balance Centers

CHILD PATIENT HISTORY

Child's Name _____

Date of Birth _____

Date of Evaluation appointment _____

Referred for (Circle all that applies):

Speech Therapy Occupational Therapy Physical Therapy

1. What is the main concern for requesting this evaluation/therapy?

   _____

   _____

   _____

2. List any of the child's medical history pertinent to this appointment.

   _____

   _____

   _____

   _____

3. List all medications the child currently takes.

   _____

   _____

   _____

4. List any past or upcoming surgeries.

   _____

   _____

   _____

5. List any allergies.

   _____

   _____

OVER

6. Any swallowing difficulties? YES NO (circle appropriate response)

7. Is child at risk for seizures? If yes, describe current procedure when a seizure occurs.

_____

_____

_____

_____

8. List all physicians the child currently sees (pediatrician, neurologist, orthopedist, etc.):
   Name: Phone #:

_____ _____

_____ _____

_____ _____

9. Does the child receive PT/OT/Speech at school? (circle each therapy received)

10. Name of school if therapy is provided. _____

11. List child's favorite toys or activities.

_____

_____

_____

12. Any other pertinent information we need to be aware of?

_____

_____

_____

_____

_____ _____

Printed name of person completing this questionnaire Date

_____ _____

Signature Relationship to child

To e-mail by pressing "E-Mail" button, you will need desktop application such as Outlook or Mail. You can also save the PDF and send as an attachment to mbarbour@fyzicalnebraska.com or crodgers@fyzicalnebraska.com.

PRINT E-MAIL