



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 #:

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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