Handprints & Footsteps
Pediatric Therapy

MEDICAL HISTORY FORM

IDENTIFYING INFORMATION

Child's name: _____ Date of Birth: _____

Parent(s)/Legal Guardian(s): _____

Address: _____

_____

Home Phone: ( ) _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Email address: _____

Are we allowed to leave a message at these numbers or email you? ☐ Yes ☐ No

If No, then how would you like to be contacted? _____

Other family members:

Name	Age	Any difficulties with development, education, etc.

Primary language spoken in the home: _____

School Name/Grade level if applicable: _____

PHYSICIAN INFORMATION

Primary Physician Name: _____ Physician Practice Name: _____

Address: _____ Physician Phone Number: _____

_____

Secondary Physician Name: _____ Physician Practice Name: _____

Address: _____ Physician Phone Number: _____

_____

Please check any other Specialists that your child is followed by and list their name and practice :

☐ Orthopedist _____ ☐ Neurologist _____

☐ Pulmonologist _____ ☐ ENT _____

☐ Geneticist _____ ☐ Psychologist _____

☐ Occupational Therapist _____ ☐ Speech Therapist _____

☐ Physical Therapist _____ ☐ Case Manager _____

☐ Other _____ ☐ Other _____

INSURANCE INFORMATION

Person Responsible for Bills (who is responsible for all unpaid balances, copays and deductibles):

Name: _____ Social Security Number: _____

Relationship to Patient: ☐ Mother ☐ Father ☐ Legal Guardian ☐ Other: _____

Home Phone: ( ) _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Address: _____

_____

Does the child have: ☐ Medicaid OR ☐ HealthChoice

Primary Insurance Name: _____ Policy Holders Name: _____

Policy ID #: _____ Group ID #: _____ Relationship to Patient: _____

Address: _____

Phone Number: _____

Secondary Insurance Name: _____ Policy Holders Name: _____

Policy ID #: _____ Group ID #: _____ Relationship to Patient: _____

Address: _____

Phone Number: _____

REASON FOR REFERRAL

Referred by: _____

Reason for visit: _____

_____

Previous Diagnosis (list type and dates): _____

_____

_____

Previous Evaluations (list type and dates): _____

_____

Current/previous treatment (list type and dates): _____

_____

_____

What are your current concerns about your child? _____

_____

_____

What are your goals for therapy? _____

_____

_____

PAST MEDICAL INFORMATION

Birth History:

Pregnancy: ☐ Full Term ☐ Pre-term: # of wks_____ ☐ Post-term: # of wks _____

Vaginal: Yes No Caesarean: Yes No Breech: Yes No Twins or More: Yes No #_____

Weight at Birth: _____lbs _____ozs. Length at Birth: _____in. Low Birth Weight: ☐ Yes ☐ No

Was conception: ☐ Natural ☐ IVF ☐ In-Vitro ☐ Surrogate

Apgar at 1 min: _____ Apgar at 5 min: _____ Length of stay in NICU: _____

Any complications at birth or afterwards? (ie. induced, emergency caesarean, forceps, suction, etc): _____

_____

_____

_____

_____

Medications:

Please list all current medications and dosage: _____

_____

_____

MEDICAL CONDITIONS

Condition	✔	Age	Explanation
Seizures			
Respiratory issues (ie. asthma, allergies, chronic cold/cough)			
Abnormal vision/blindness/glasses			
Impaired hearing/deafness			
Heart disorders			
GI issues			
Meningitis			
Autoimmune compromised			
Meningitis			
Frequent hospitalizations			

FAMILY MEDICAL HISTORY

Family History of:	✔	Relationship	Explanation
Developmental Delay			
Genetic Disorders			
Learning Disorders			
Socio-Emotional Disorders			
Speech/Language Delay/Disorder			
Autism/Autism Spectrum Disorders			
Other:			

DEVELOPMENTAL MILESTONES

Were your child's developmental milestones: ☐ Normal ☐ Delayed ☐ Advanced

What age were the following milestones achieved (record in months or years if able)?

Rolling: _____ Sitting alone: _____ Crawling: _____ Standing: _____ Walking: _____

Held bottle independently: _____ Finger feeding: _____ Used Spoon: _____ Fork: _____

Use a crayon: _____ Use scissors:_____ Dress self: _____ Drink from a cup: _____

Talking: Babbling: _____ Single words: _____ 2-3 word sentences: _____ Speak clearly: _____

CURRENT MEDICAL INFORMATION

General Health of Your Child: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Sleep patterns: ☐ Excellent ☐ Good ☐ Fair ☐ Poor Explain:_____

Eating patterns: ☐ Excellent ☐ Good ☐ Fair ☐ Poor Explain:_____

Does your child have a current IFSP/IEP? ☐ Yes ☐ No

Does your child need the assistance of a: ☐ Feeding Tube ☐ Ventilator ☐ Other:_____

_____

Are there any Allergies, Medical Concerns or Precautions we need to be made aware of (ie. latex allergy, tape allergy, peanut allergy, special diet, etc)? _____

_____

How does your child currently communicate (ie. gestures, signs, cued speech, eye gaze, crying, words, aug comm device)? _____

_____

Does your child have any adaptive/medical equipment? ☐ Yes ☐ No If Yes, please explain: _____

_____

PRESENT ABILIITES/STRENGTHS

Describe your child's ability in the following:

Gross Motor Skills:

Skill	Always (100%)	Frequently (75%)	50% of the time	Rarely (25%)	Never (0%)
General coordination is good					
Strength and endurance is average					
Balance is good, does not lose balance easily					
Does not trip over obstacles					
Able to hop					
Able to jump off the ground					
Able to jump forward					
Catches a ball accurately					
Throws a ball accurately					
Able to ride a tricycle or bicycle					
Able to protect self when falling					

Fine Motor Skills:

Skill	Always (100%)	Frequently (75%)	50% of the time	Rarely (25%)	Never (0%)
Has a dominant hand					
Holds a pencil correctly					
Colors within the lines					
Writes their name neatly					
Holds scissors correctly					
Cuts along a line					
Manipulates small objects (ie. legos, blocks)					
Threads small beads					
Draws people and other objects					
Able to paste without a mess					
Plays with playdoh or clay					
Able to point to pictures and objects					

Oral Motor/Verbal Skills:

Skill	Always (100%)	Frequently (75%)	50% of the time	Rarely (25%)	Never (0%)
Able to suck from a straw					
Able to blow out candles					
Able to swallow different foods					
Aware of food around mouth					
Able to chew well					
Manages speech sounds(verbal communication)					
Non-verbal communication					
Communicates via augcomm device					

Attention and Thinking Skills:

Skill	Always (100%)	Frequently (75%)	50% of the time	Rarely (25%)	Never (0%)
Follows simple instructions					
Follows two step instructions or more					
Able to concentrate on a task					
Listens to others					
Understands what was asked					
Manages simple puzzles and games					
Able to change tasks easily					
Able to organize self for school/activities					

Self Care Skills:

Skill	Always (100%)	Frequently (75%)	50% of the time	Rarely (25%)	Never (0%)
Dresses independently					
Able to fasten buttons and use zippers					
Able to tie shoelaces					
Puts shoes on correct feet					
Manages toilet independently					
Able to wash hands independenty					
Eats without making a mess					

Uses a fork and spoon appropriately					
Uses a knife appropriately					
Pours a drink without spilling					
Able to brush hair independently					
Able to brush teeth independently					
Independent with bathtime routine					
Aware of safety in the home and community					
Assists with household chores					
Follows rules in the home and community					

Socio-Emotional Skills:

Skill	Always (100%)	Frequently (75%)	50% of the time	Rarely (25%)	Never (0%)
Attention seeking behavior					
Friendly and easy going child					
Fussy and irritable					
Confident and has self esteem					
Anxious or withdrawn child					
Activity level appropriate to task					
Engages in eye contact					
Initiates games with peers					
Expresses self appropriately					
Manages temper and frustration					
Aggressive behaviors seen					
Talkative					
Needs to be the leader					
Fearful of new situations					

Play Skills:

Skill	Always (100%)	Frequently (75%)	50% of the time	Rarely (25%)	Never (0%)
Able to play on own					
Able to play with others					
Makes and keeps friends					
Confident and has self esteem					
Able to share and take turns					

Uses imagination in play					
Able to follow rules					
Prefers to play inside					
Prefers to play outside					

How would you describe your child's temperament?

What do you perceive as areas that are challenging for your child or for you in parenting your child?

What do you want to see improve with physical, occupational and/or speech therapy?

Please list a few of the play activities at home that your child enjoys:

Please feel free to list any other pertinent information that you feel we need to best serve both you and your child.

Thank you so much for taking the time to complete this form and allowing us to serve you and your child!

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