Medical History Form

Client: _____ Male ☐ Female ☐ Date of birth: _____

Name of Person Completing this Form: _____ Relationship: _____

Preferred Language: _____

Reason for referral for therapy: _____

_____

Parent or Caregiver concerns: _____

_____

Birth History

Delivery type: Vaginal ☐ or C-section ☐ Vacuum or forceps assisted: Yes ☐ No ☐

Difficulties during pregnancy: Yes ☐ No ☐ If yes please explain: _____

_____

Difficulties during delivery: Yes ☐ No ☐ If yes please explain: _____

_____

Gestational Age: Full term ☐ or Premature ☐ If premature, born at _____ weeks

Apgar Score (if known): _____ Duration of hospital stay post birth: _____

Did client have any problems with the areas below? Please check all that apply:

☐ Jaundice ☐ Colic ☐ Feeding Problems ☐ Reflux ☐ Head Shape /tilt

Health History

Does client have any allergies? Yes ☐ No ☐ If yes please list: _____

_____

Does client have a diagnosis? Yes ☐ No ☐ If yes please list: _____

_____

Is the client on any medications? Yes ☐ No ☐ If yes please list: _____

_____

Has the client had a head injury, concussion, fracture or stitches? Yes ☐ No ☐ If yes please explain:

_____

_____

Has the client ever been hospitalized? ? Yes ☐ No ☐ If yes, please explain and give age at each hospitalization: _____

_____

Has the client ever had a seizure? Yes ☐ No ☐ If yes, date of first seizure: _____
Since the first seizure, how many seizures has the client had? _____

Has the client had any special test performed for the condition with they are seeking therapy?

☐ X-Ray ☐ MRI ☐ CT Scan ☐ Other: _____

Has the client ever had any operations? Please list operation and year completed.

_____

_____

Has the client had a history of or currently experiencing any of the following conditions?

☐ High Blood Pressure	☐ Osteopenia/Osteoarthritis	☐ Asthma	☐ Hepatitis
☐ Low Blood Pressure	☐ Scoliosis	☐ Cancer: (type) _____	
☐ Seizures	☐ Hip Dysplasia	☐ Stroke: (what age) _____	
☐ Cerebral Palsy	☐ Diabetes	☐ Rheumatoid Arthritis	
☐ Heart Murmur	☐ Down Syndrome	☐ Other: _____	

Please check all that apply to client:

☐ Tracheostomy	☐ Hearing Aids	☐ Hearing difficulties	☐ Glasses
☐ Latex sensitivity	☐ G- tube	☐ Colostomy	☐ Central Line
☐ Helmet	☐ Crutches/walker	☐ Stander	☐ Wheelchair (manual or power)
☐ Splints : (for) _____		☐ Braces: (for) _____	
☐ Respiratory Limitations	☐ Oxygen _____L.	☐ Weight bearing status: _____	

Other or comments: _____

Does the client have any difficulty performing age appropriate activities listed below? (Check all that apply)

☐ Reaching/grasping	☐ Sitting	☐ Walking	☐ Dressing
☐ Toileting	☐ Bathing	☐ Feeding	☐ Social Interaction

Medical Personnel

Has the client been seen by any doctor/medical personnel other than a pediatrician/ family practitioner?

☐ Neurologist ☐ Neurosurgeon ☐ Dentist ☐ Gastroenterologist

☐ Psychologist ☐ Psychiatrist ☐ Ear Nose & Throat ☐ Optometrist/Opthamologist

☐ Occupational Therapist ☐ Physical Therapist ☐ Speech Therapist ☐ ABA Therapy

☐ Other: _____

Has the client received therapy for the condition they are seeking therapy today for, previously?

Yes ☐ No ☐ if yes please list: _____

School

Does the client attend school? Yes ☐ No ☐ If yes, please fill out the information below

What school does the client attend? _____

☐ Regular Education ☐ Special Education Grade: _____

Does the client receive any services at school? Yes ☐ No ☐ If yes please check below

☐ Occupational Therapy ☐ Physical Therapy

☐ Speech Therapy ☐ Other: _____

Is your child a client of Kern Regional Center? Yes ☐ No ☐ If yes, please list their services:

_____

Thank You for taking the time to fill out this questionnaire. This information will help us to become more familiar with the client so that we can provide the best service possible to you and the child.

_____ _____

Signature *Date*