Pediatric Physical & Occupational Therapy, PLLC

Medical History

General Information

Child's Name:_____ Date of Birth:_____

Medical Information

Has your child received a previous evaluation and or treatment by a physical/occupational therapist?
If yes, when and where. _____

_____

Has your child had any of the following? If yes, describe and give approximate dates.

Childhood diseases or major illnesses:_____

_____

Congenital Abnormalities: _____

Surgery:_____

Serious Injury:_____

Casts or Braces:_____

Ear Infections or Tubes in Ears_____

Allergies:_____

Seizures:_____

Other:_____

List any medications your child is currently taking:_____

Does your child have any assistive devices? (Glasses, braces, wheelchair, etc)_____

What do you hope to gain by this evaluation and/or treatment?_____

_____

Parent/Guardian Signature: _____ Date: _____