Medical History Form

Patient Name: ___________________________________ **Date of Birth:** ____________

Pregnancy / Delivery

Pregnancy Proceeded

Without complications

With complications: (select all that apply)

Eclampsia	Positive for Strep B
Gestational diabetes	Pre-eclampsia
Multiple births	Premature labor
Polyhydramnios	Substance exposure
Positive for Herpes	Toxemia
Positive for 'CMV'	Positive for HIV
Cytomegalovirus	Other: _____________

Length of pregnancy: ________ weeks

Prenatal care was: Received Not received

Delivery proceeded

Without complications

With complications: (select all that apply)

Abruptio placenta	Breech presentation
Low birth weight	Negative vacuum
Non-progressive/	Placenta previa
Unproductive labor	Transverse presentation
Occiput posterior	Prolapsed cord
Position (face up)	Use of forceps
Premature rupture	Uterine rupture
of membranes	Other:
Umbilical cord wrapped	
around neck	

Delivery was: Vaginal C-section Emergency C-section

Length of child's hospital stay: _______________

Mother's age at time of birth: ________________ years

Medical History Form

Birth Hospital: _________________________ City: ____________ State: ____________

Was there a need to transfer child to another hospital: Yes No

If transfer was required, what was the cause? __________________________________

Transfer Hospital Name: ______________________ City: ____________ State: ____

Birth Weight: ________ Birth Height: _______ Apgar: 1 min ____ 5min____ 10min____

Additional details on birth:

Was child adopted? Yes No

If child was adopted, please provide additional details:

Infancy & Early Childhood

Complications following birth: (select all that apply)

- Anemia of prematurity
- BPD (Bronchopulmonary Dysplasia)
- Cleft lip
- Cleft palate
- Club foot
- Cytomegalovirus
- ECMO
- Failure to Thrive
- Hyperbilirubinemia
- IUGR (Intrauterine Growth Retardation)
- IVH Bleed Grade I
- IVH Bleed Grade II
- IVH Bleed Grade III
- IVH Bleed Grade IV
- Jaundice (treated by light therapy and/or blanket)
- Meconium aspiration
- NEC (Necrotizing Enterocolitis)
- Neonatal hypoxia
- Oxygen dependency
- PDA (Patent Ductus Arteriosus)
- Positive dependency
- RDS (Respiratory Distress Syndrome)
- Respiratory Stridor
- RSV (Respiratory Syncytial Virus)
- ROP (Retinopathy of Prematurity)
- Thrombocytopenia (low platelet count)
- Ventilator dependency
- VP Shunt

Other: ____

Medical History Form

Diagnosed or Suspected Syndromes

Current Prescribed Medications:

Medication Name	Prescribed Dose	Prescribed Frequency

Current Over-the-Counter Medications:

Medication Name	Dose Taken	Frequency	Used to Treat

Allergies:

Allergy	Reaction

Current vitamins, herbs, minerals, and/or homeopathies:

Medical History Form

Hearing Test:

Never tested, no concerns
Never tested, have concerns
Normal test results
Abnormal test results

Last test date: _____________

Results: ____

Concerns: ____

Vision Test:

Never tested, no concerns
Never tested, have concerns
Normal test results
Abnormal test results

Last test date: ______________

Results: ____

Concerns: ____

Current Physicians:

Physician Name	Specialty	Reason	Date of Last Visit

Medical History Form

Diagnostic Tests:

Test	Date of Test	Details/Results
Auditory Brainstem Response		
Biopsy		
Blood work / Lab tests		
Bone density scan		
CT scan		
EEG		
EMG		
Lower GI		
Motility study/ Empty scan		
MRI		
NCV		
Swallow study		
Ultrasound		
Upper Endoscopy		
X-Ray		
Other:		
Other:		
Other:		

Surgeries and Procedures:

Type	Date	Results/Details

High Hopes
DEVELOPMENT CENTER

Medical History Form

Does the child have:

Allergies
AVM (Arteriovenous Malformation)
Anoxic brain injury
Asthma
Autism
Baclofen pump
CP (Cerebral Palsy)
CVA (Cerebral Vascular Accident)
Tube feeding
Chronic ear infections
Colic
Constipation
Diarrhea
Down Syndrome
Hip subluxation
Hydrocele
Laryngomalacia
Muscular Dystrophy
Osteoporosis
Periventricular
Leukomalacia
Reflux
Scoliosis; degrees? ____
Seizure condition
Sleep disorder
Sleep problems
Shunts
Torticollis
TBI (Traumatic Brain Injury)
Tubes in ears
Vagal nerve
Stimulator
None

Other Medical Conditions:

Orthopedic Conditions:

Additional Comments:

Developmental History

Is your child: Right-handed Left-handed Neither

Do you have concerns about handwriting? No Yes; describe: ___________________

How does your child get around the home? ____

Favorite Toys/Play Activities? ____

Medical History Form

Complete the following for each activity listed:

When did the child begin?	Began at age (in months if earlier than 2 years of age)	Any Concerns
Bringing both hands to mouth		
Buttoning pants/shirt		
Come to sitting from a lying position		
Creeping or crawling alone		
Fully toilet trained		
Grabbing a toy		
Holding head up alone without support		
Pulling self to standing position		
Rolling over		
Self-bathing		
Self-dressing		
Sitting along without support		
Standing unsupported		
Tying shoes		
Walking with support		
Walking unaided		
Zipping/unzipping jacket		

Description of Child

My child is: (select all that apply)

Active
Affectionate
Aggressive
Calm
Cautious
Curious
Demanding
Difficult to comfort
Distractible
Fearful
Fearless
Fussy
Insecure
Motivated
Passive
Persistent
Playful
Shy
Stubborn
Withdrawn
Other:

Medical History Form

Sensory Processing & Regulation

Select all that apply:

- Avoids getting messy
- Stumbles or falls frequently
- Flap hands
- Spins things or self
- Fatigues quickly
- Has self-abusive behaviors
- Has difficulty falling asleep
- Sleeps a lot
- Resists touch
- Walks on toes
- Lines up toys or objects
- Allows brushing of teeth
- Seeks out stimulating sounds
- Bangs on surface, bangs/hits head
- Hyper-focused (on tasks, people, objects)
- Has poor sense of body space and often runs into objects
- Has difficulty sleeping through night
- Seeks out (craves) touch or movement
- Appears awkward or less coordinated
- Appears lethargic/sleepy all the time
- Resists certain tasks or environment
- Has difficulty figuring out how to move body or takes more time with movements
- Is sensitive to lights, sounds, or noise
- Seeks out visually stimulating objects
- Resists certain movements (e.g. bouncing, swinging, upside down)
- Does not tolerate certain textures (e.g. clothing, surfaces, foods, etc.)
- Uses lots of pressure when touching someone or holding objects
- Demonstrates stiff or rigid movement patterns
- Seeks support for posture (e.g. leans on furniture, walls, or people, holds head)

Other:

Social/Emotional Skills

Check all that apply:

- Is easily distracted
- Only plays with adults
- Does not allow others to join in play
- Gets angry/frustrated easily
- Has difficulty with separations
- Plays with peers
- Prone to emotional outbursts
- Calms self easily
- Prefers to play alone
- Has difficulty making friends
- Is aggressive towards others
- Has poor eye contact

Other: ____

Medical History Form

Feeding

Describe any feeding problems or concerns:

Likes & Dislikes: List in appropriate column

Food Likes	Food Dislikes

Feeding Milestones:

Milestone	Age (in months)	Milestone	Age (in months)
Using a bottle		Using a straw	
Using a pacifier		Stopped using a bottle	
Eating baby food		Stopped using a pacifier	
Eating junior food		Using utensils to eat	
Eating table food		Holding own bottle/cup	
Drinking from a sippy cup		Self-feeding	
Drinking from cup		Other:	

Breast Feeding

Child was breast fed and fed ______ times per day

Child is currently breast feeding   Yes   No, child was weaned at age _____

Child was never breast fed

Current Feeding Adaptations

Thickened liquids   Consistency: ____

Adapted utensils   Details: ____

Adapted seating   Details: ____

Calorie supplements   Details: ____

Tube feeding   Amount: _____________   Frequency: _______________

Continuous   Bolus

Medical History Form

Areas of Difficulty

Chewing
Swallowing
Drooling
Understanding Words
Transitioning between foods
Jaw shifts/slides/juts
Communicating needs
Other: ______________________________________

Speech Language

Communication Skills:

Does your child:	Yes	No
Have speech that is understood by most people		
Respond correctly to yes/no questions		
Follow simple instructions		
Respond when their name is called		
Stutter		
Recognize objects, people, and places		

Speech Milestones

When did the child begin?	Age (in months)
Babbling	
Saying first words	
Naming familiar objects	
Putting 2 words together	
Using short sentences	

First words: ____

Augmentative Communication Device: ____

Primary Communication:

Verbal
Non-verbal
None

Methods of communication used:

Vocalizations
Pointing
Facial Expressions
Complete sentences
Eye gaze
2-Word phrases
Single words
Body language
Manual sign language
Gestures

Medical History Form

Please describe current speech concern:

Home Environment

Child lives with: (select all that apply)

Birth mother	Stepmother	Legal guardian: (specify) ____________
Birth father	Stepfather	Siblings: (ages) ___________________
Adoptive mother	Grandmother	Other relatives: (relation)
Adoptive father	Grandfather	

Additional comments:

Type of Home:

Single level house	Assisted living facility
2 level house	Skilled nursing facility
Ground floor apartment	Group home
Upper level apartment	Other: _____________________________________

Accessibility

# of stairs to get into home: _________

If there are stairs to get into home is there a handrail? Yes No

If there is a handrail is it on the Right-side Left-side

# of stairs in home: __________

If there are stairs in the home, is there a handrail? Yes No

If there is a handrail is it on the Right-side Left-side

Child's bedroom is on the Main level Upper level

Child's bathroom is on the Main level Upper level

Additional comments:

Medical History Form

Equipment Presently Used

Select all that apply:

Equipment	Began Using at Approx. Age	Details	Uses at Home	Uses at School/Day Care
Braces				
Walker				
Stander				
Manual wheelchair				
Power wheelchair				
Hoyer lift				
Weighted vest				
Hand splint(s)				
Track system				
Other:				
Other:				
Other:				

Describe any home program currently performed (e.g. stretching, strengthening, brushing, etc.):

Describe any community groups or sports activities the child is involved in:

Is your child currently enrolled in school? Yes No

Current grade in school: ____________ School Name: __________________________

Does your child have an FSP? Yes No

Does your child have an IEP from school? Yes No

Has your child completed a psychological or neuropsychological evaluation? Yes No

Medical History Form

Has your child had any of the following therapy services? (Complete for all that apply)

Therapy Service	Have Participated?	Status (Active/Inactive)	Frequency	Clinic Name	Last Appt. Date
Assistive technology					
Audiology					
Behavior therapy					
Developmental therapy					
EI services					
Intensive suit therapy					
Vision therapy					
Nutrition					
Occupational therapy					
Physical therapy					
Social therapy					
Speech/language therapy					
Feeding therapy					
Developmental follow-up clinic					
Other:					

Additional Comments:

Form Completed By: ____________________________________

Relationship to Patient: __________________________________

Date Completed: _______________