Medical History Form

Child's Name:____

Language(s) spoken at home:____

Please list any and all allergies:____

Current medications:____

Pregnancy History

☐ Pre-Term; Gestational Age:_____________ ☐ Full Term Weight at Birth:___________

Complications during Pregnancy/Delivery? ☐ Yes ☐ No

If "Yes" please list complications:____

____

Medical History

Please check if your child has a diagnosis of any of the following:

☐ Autism/Asperger's	☐ ADHD	☐ OCD	☐ Diabetes
☐ Developmental Delay	☐ Learning Disability	☐ Cerebral Palsy	☐ Prematurity
☐ Speech Delay	☐ Anxiety	☐ Seizure	☐ Other: Please notate below

If "Other" please list:____

Please check if your child has experienced the following:

☐ Seizures (Including Febrile Seizures) When:_______________________

☐ Head Injury/Concussion When:_______________________

☐ Ear Infections When:_______________________

☐ Ear Tubes When:_______________________

☐ Major Illness/Hospitalizations When:_______________________

☐ Surgery When:_______________________

Is your child currently under the care of another specialist?

If so, please list other specialties:____

Other Relevant Family History:____

Please save completed form to your computer and email completed form to eileen@handledtherapy.com or to the email provided by your therapist.