Medical History

Date: _____

Name_____ DOB _____

Phone Number _____

Current Symptoms_____

_____

Have you ever been to other doctors/facilities for this same problem?_____

_____

Any Known Allergies _____

Check below if you have or have had any problem in these areas or conditions:

____Kidneys	____Currently taking Anticoagulant	____Self-Stimulating Behaviors
____Weight Loss	____Broken Bones	____Significant Birth History
____Cancer/Tumors	____Headaches/Migraines	____Ears: Hearing/Infections
____Seizures	____Paralysis	____Injurious Behavior
____Depression	____Bowel/Bladder Problems	(self/others)
____Meningitis	____Arthritis	____Behavioral Changes
____High Blood Pressure	____Stroke	____Paying Attention
____Sleeping	____Vision/Perceptual Problems	____Handwriting
____Asthma	____Respiratory Problems	____Handling Small Items
____Heart Condition/ Pacemaker	____Skin	____Speaking/ Understanding
____Diabetes	____Hepatitis B, Hepatitis C or HIV	____Swallowing/ Drooling
____Swelling of Limbs	____Currently Pregnant	____Walking/Stepping/Running
____Incoordination	____Osteoporosis	____Delayed Development

List surgeries/ hospitalizations/ accidents:_____

_____

_____

Is your injury due to a motor vehicle accident? YES / NO Is your injury due to a work comp case? YES / NO

Are you currently receiving school or home health therapy? YES / NO

Please list any medications you take:	

State your goals for therapy: _____

_____

I, _____ certify that the information listed above is accurate and that should my condition change during course of therapy, it is my responsibility to notify my therapist to ensure my safety.

Signature: _____ Date: _____