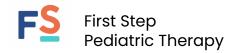


| Patient name: | | Date of Birth: | | | |
|--|-------------------|----------------|--------|-----------------|--|
| Today's date: | | | | | |
| What are your child's current symptoms/diag | | currently? | | | |
| | | | | | |
| | | | | | |
| When/how did they begin?: | | | | | |
| | | | | | |
| | | | | | |
| How much does this condition limit your chil | d's normal activi | ty level? Circ | le one | | |
| 0 (bed rest) 1 2 3 4 Explain: | 5 6 7 | 7 8 | 9 | 10 (not at all) | |
| | | | | | |
| | | | | | |
| Have you had previous treatment or recent testing (imaging, x-ray) for this condition? | | | | | |
| | | | | | |
| | | | | | |
| History of fractures, significant injuries, or major hospitalizations?: | | | | | |
| | | | | | |
| | | | | | |

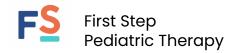


| Does your child receive any other outside services (OT, SLP, ABA, etc) or have an IEP? | | | | | |
|--|--|--|--|--|--|
| | | | | | |
| | | | | | |
| What are your family's priorities/goals for therapy?: | | | | | |
| | | | | | |
| | | | | | |



Medical History

| Is your child taking any medications?: | | | | | | |
|--|----------------------------------|--------------------------|--|--|--|--|
| | | | | | | |
| | | | | | | |
| Does your child have any allergies or o | ther precautions?: | | | | | |
| | | | | | | |
| Does your child have a significant birth complications)? | history (prematurity, NICU stay, | , pregnancy and/or birth | | | | |
| | | | | | | |
| Does your child have a history of any o | f the following: | | | | | |
| Asthma/respiratory concerns | Cancer | Diabetes | | | | |
| Hearing problems | Heart conditions | Hydrocephalus | | | | |
| V/P shunt placement | Reflux/GI issues | Vision problems | | | | |
| ADD/ADHD | Surgery | Stroke | | | | |
| Psychiatric diagnosis | Seizures | Skin conditions | | | | |
| Explain: | | | | | | |
| | | | | | | |



Seizures

| Seizure type | What happens | How long it lasts | How often | Triggers | | | | |
|--------------------|--------------|-------------------|-----------|----------|--|--|--|--|
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| Seizure first aid: | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| When to call 911: | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |