Verbal Expressions, Inc

Patient Medical Information

Child's Name_____D.O.B._____Sex___M___F

Doctor's Name/Address_____
_____

Doctor's Phone #_____Parent's Phone #_____

Parent's Name: _____

Parent's Address:_____
_____

Were there any complications with the pregnancy and/or at birth or after birth?_____
_____

Please list any significant medical histories of the child (i.e. ear infections, surgeries, allergies, falls, etc)_____
_____
_____

Please list all current medical problems, treatments, and medication(s) taken._____
_____
_____

Is there any significant family medical history? (heart problems, diabetes, psychiatric problems, Developmental disabilities, alcohol/drug abuse)_____
_____
_____

Has your child ever been evaluated by or received any of the following services:
_____Occupational Therapy_____Physical Therapy _____Speech Therapy

List all adults and children living in the home:_____

NAME: AGE RELATIONSHIP OCCUPATION/SCHOOL
_____ ____ _____ _____
_____ ____ _____ _____
_____ ____ _____ _____

Is there any other information the therapist should know in order to help your child?
_____
_____
_____

Parent's Signature:_____ Date:_____

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