Lifting Spirits Therapy Services, Inc.

Medical History Questionnaire

Name: _____ Date: _____
Date of Birth: _____ Age: _____ Height: _____ Weight: _____
Diagnosis: _____

Does your child have any of the following:
Having any of the below conditions does not exclude your child from receiving therapy service. However, this information is needed by the therapist to ensure your child's safety.

YES	NO		YES	NO	
___	___	Abnormal Fatigue	___	___	Hydrocephalus
___	___	Acute Arthritis	___	___	Excessive Swayback/Hunchback
___	___	Acute Herniated Disc	___	___	Incontinence
___	___	Agitation with confusion	___	___	Multiple Sclerosis, acute
___	___	Aneurysm	___	___	Open Wounds
___	___	Allergies (dust, mold, hay, etc)	___	___	Loss of Sensation
___	___	Arnold Chiari Malformation	___	___	Obesity
___	___	Cardiac/Heart Condition	___	___	Osteoporosis
___	___	Circulation Problems	___	___	Osteogenesis Imperfecta
___	___	Complete Quadriplegia	___	___	Pathogenic Fractures
___	___	Hip Joint Degeneration	___	___	Recent Dorsal Rhizotomy
___	___	Diabetes	___	___	Scoliosis greater than 30 degrees
___	___	Hearing Problems	___	___	Shunt(s)
___	___	Spinal Fusion	___	___	Heterotrophic Ossification
___	___	Spondylolistheis	___	___	Substance Abuse
___	___	Hip Subluxation or dyplasia	___	___	Tethered Cord
___	___	History of Seizures	___	___	Tracheostomy
___	___	Unstable Neck or Spine	___	___	Urinary Tract Infections
___	___	Vision Problems	___	___	Skin breakdowns/sin grafts
___	___	Obesity	___	___	Food sensitivities/Special Diet

If stated yes above, please specify: _____
_____
_____

List Medications: _____
_____

Surgical Procedures: What type and when (restrictions): _____
_____

Specific to Down's Syndrome
Negative Cervical X-ray for Atlantoaxial Instability? YES _____ NO _____
Does your child currently receive therapy? If so, where and type? _____
Family/Client Concerns and Goals: _____

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