PEDIATRIC THERAPY SERVICES | where children learn and leap

Medical History Information

Necessary to Secure Authorization

Patient Name:_________________________Birthdate:_______________________________
Primary Care Pediatrician: ______________Phone#________________________________
Address_______________________________Zip Code________________________________

Patient's Specialists: (list all) ____
____

Are there any changes in your doctors?☐ **Yes** ☐ **No**
If yes, please list: ____
Any changes or additions to diagnosis? ☐ ***Yes*** ☐ ***No***
If yes, please list: ____

Current Medications: Please use back if necessary

Name	Dose	Frequency	Purpose	Method
______________	________	__________	_________	______
______________	________	__________	_________	______
______________	________	__________	_________	______
______________	________	__________	_________	______

Method choices might include: PO, IV, NG, Nebulizer, Aerosol.
List child's equipment: ____
School, Daycare or Preschool child attends:_____________________Grade:____________
List special education services: ____
Other outside therapy? ☐PT ☐OT ☐ST Frequency of each__________________________

If yes, Name of provider:____
In school setting? ☐PT ☐OT ☐ST Frequency: __________________________________

PROVIDE MOST CURRENT EVALUATIONS FROM PROVIDER.
Does child require special diet/restrictions? ☐ ***Yes*** ☐ ***No***
If yes, please list: ____
Areas of concern:____
Safety Issues: ____
Therapy goals? ____

The information above has been completed to the best of my knowledge and ability.

Printed Name:____________________________Relationship to Patient________________

Signature:____ Date:____________________

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