Curative Care
New Berlin Therapies
Dedicated to Helping People Thrive

Curative New Berlin Therapies, LLC
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Infant Medical History Form

Patient Name: ____ **DOB:** ______________________

Reason for Referral: ____

Diagnoses: ____

Surgeries, Hospitalizations, Major Illnesses, Injuries: ____________________________________

____

Medical Tests: (*Please check all that apply and list results below*)

☐ Genetic ☐ X-Rays ☐ CT Scan ☐ EEG/EKG ☐ MRI ☐ Swallow Study ☐ Upper GI
☐ Audiologist ☐ Other______________________________

Test Results: ____

____

Previous Therapy History: ____

____

Other physicians or therapists involved in your child's care:

Name: ____ Specialty: ________________________
Name: ____ Specialty: ________________________
Name: ____ Specialty: ________________________

Medications:

Type/Name:	**Dosage/Frequency:**	**Medication For:**

Allergies: ☐ No/None Known ☐ Yes: ____

Precautions: ☐ No/None Known ☐ Yes: ____

Does your Child have a Do-Not-Resuscitate (DNR) order? ☐ Yes ☐ No

Pregnancy/Birth History:

Typical Pregnancy: ☐ Yes ☐ No (if no, please explain):___________________________________

Premature Birth (less than 38 weeks): ☐ No ☐ Yes - # of Weeks Gestation: ___________________

Sleep: Does your child have any sleep problems? ☐ No ☐ Yes (if yes, explain): ______________

____

Motor Development:

Does your child have any delays in gross motor development (i.e. rolling over, sitting, crawling, etc)?

☐ No ☐ Yes (if yes, explain): ____________________

Does your child have any delays in fine motor development (i.e. reaching, grasping, manipulating play materials, manipulating clothing fasteners, etc)? ☐ No ☐ Yes (if yes, explain): ____________________

Social/Emotional: Does your child have any attention concerns, sensory sensitivities and/or other issues? ☐ No ☐ Yes (if yes, explain): ____________________

Vision Concerns: Does your child have any vision issues? ☐ No ☐ Yes (if yes, explain): ____________________

Hearing Concerns: Does your child have any hearing issues? ☐ No ☐ Yes (if yes, explain): ____________________

Feeding/Swallowing Concerns: Does your child have any feeding or swallowing issues? ☐ No ☐ Yes (if yes, explain): ____________________

Home Environment:

Child Lives With: ☐ Biological Parent(s) ☐ Foster Parent(s) ☐ Legal Guardian ☐ Adoptive Parent ☐ Other

Child's Parents Are: ☐ Married ☐ Unmarried ☐ Separated ☐ Divorced

Child care situation: ☐ Parent(s) ☐ Others (specify who and hours per day) ____________________

What are **your child's strengths**? ____________________

What are **your concerns** about your child? ____________________

What are **your child's favorite toys**? ____________________

What are **your goals** for your child? ____________________

***If there is any specific information which has not been requested on this form that you think would help us in understanding your child, please include here*:** ____________________

Parent/Guardian Signature ____________________ Date ____________________

Therapist Signature ____________________ Date ____________________