Curative Care
New Berlin Therapies
Dedicated to Helping People Thrive

Curative New Berlin Therapies, LLC
2895 S. Moorland Road
New Berlin, WI 53051
262-782-9015

Pediatric 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
☐ Neuropsych ☐ Psychologist ☐ Psychiatrist ☐ 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

Special Equipment Currently in Use: (*Please check all that apply*)

☐ Glasses/Corrective Lenses ☐ Orthotics ☐ Splints ☐ Wheelchair/Seating Device
☐ Walker ☐ Canes ☐ Augmentative Communication Device ☐ Other ____________________

Pregnancy/Birth History:

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

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

Academic/Education: ☐ Child does not attend school

School/Grade: _____________________________________ School Phone #: __________________

Therapy Received at School: ☐ None ☐ Physical Therapy ☐ Occupational Therapy ☐ Speech

Academic Concerns: ☐ No ☐ Yes (explain): ____

____

Speech and Language Development:

My child communicates by… (*Check any of the following that apply:)*

☐ Gestures ☐ Eye Gaze ☐ Crying ☐ Sign Language ☐ Single Words ☐ Phrases

☐ Conversation ☐ Augmentative Device (type of device:___________________________)

Does your child have delays with speech (i.e. hard to understand, stuttering, difficulty following directions, limited speech, etc.)? ☐ No ☐ Yes (if yes, explain): ______________________________

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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): ___________________

____

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

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Social/Emotional/Behavioral Concerns: Does your child have any attention concerns, sensory sensitivities and/or behavioral 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? ____

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____

***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*:** ______________________________

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____

______________________________________ ______________________________
Parent/Guardian Signature Date

______________________________________ ______________________________
Therapist Signature Date