MAINELY INTENSIVE THERAPIES

MEDICAL INFORMATION FORM

CHILD'S NAME: ☐ Male ☐ Female

DATE OF BIRTH:

PARENT / GUARDIAN NAME:

ADDRESS:

PHONE: HOME WORK FAX

E- MAIL:

1. WHAT IS THE CHILD'S DIAGNOSIS?

2. CHILDS INFORMATION:

- HEIGHT
- WEIGHT
- CHEST CIRCUMFERENCE
- WAIST CIRCUMFERENCE
- THIGH CIRCUMFERENCE

3. MEDICAL STATUS:

HISTORY OF FRACTURES	☐ Yes	☐ No
HISTROY OF INHIBITIVE / SERIAL CASTING	☐ Yes	☐ No
HISTROY OF BOTOX / PHENOL INJECTIONS	☐ Yes	☐ No
SENSATION / LOSS FOF FEELING	☐ Yes	☐ No
SEIZURES (date of last one)	☐ Yes	☐ No
SCOLIOSIS	☐ Yes	☐ No
HEART PROBLEMS / HYPERTENSION	☐ Yes	☐ No
SURGERIES	☐ Yes	☐ No
LUNGS PROBLEMS	☐ Yes	☐ No
DIABETES	☐ Yes	☐ No
VISION/HEARING	☐ Yes	☐ No
SHUNTS (hydrocephalus)	☐ Yes	☐ No
TRACHEAL / G- TUBE	☐ Yes	☐ No
KIDNEY PROBLEMS	☐ Yes	☐ No
WOUNDS, ULCERS	☐ Yes	☐ No
SKIN PROBLEMS (infections, inflammations)	☐ Yes	☐ No
PREVIOUS THERAPY	☐ Yes	☐ No

4. IF YOU ANSWER YES TO ANY OF THE ABOVE QUESTIONS PLEASE EXPLAIN AND PROVIDE CONTACT INFORMATION FOR ANY SPECIALIST WHO TREATS YOUR CHILD.

5. PLEASE LIST ANY MEDICATIONS YOUR CHILD IS CURRENTLY TAKING. (Reason for taking.)

6. HOW DO YOU COMMUNICATE WITH YOUR CHILD / HOW DO THEY COMMUNCATE WHY YOU?

7. IS YOUR CHILD ABLE TO FOLLOW SIMPLE COMMANDS?

8. CHILD'S ABILITIES (rolling, sitting, crawling and walking)

9. LIST OF MEDICAL EQUIPMENT THAT YOUR CHILD IS USING: (braces, walker, crutches, wheelchair)

10. DOES YOUR CHILD HAVE A LEG LENGTH DISCREPANCY? (If so please provide length measurements of both legs)

11. DOES YOUR PHYSICIAN ADVISE YOU NOT TO PARTICIPATE IN INTENSIVE PHYSICAL ACTIVITIES? (why? contraindication)

12. HAVE YOU EVER BEEN DENIED THERAPY AT ANY INTENSIVE OR TRADTIONAL CLINIC? (If yes please explain)

13. PLEASE COMMENT BELOW ON YOUR CHILD'S HABITS. (eating habits, water/fluid intake, nap schedule etc.)

14. PLEASE PROVIDE US WITH WRITTEN HIP X-RAY REPORTS. (No older than 6 months)

15. DATE SUBMITTED Click here to enter a date.

PLEASE PRINT AND MAIL / FAX COMPLETED FORM TO:

MAINELY INTENSIVE THERAPIES

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