dynamic strides THERAPY

Patient's Medical History

(To be completed by Patient or Patient's guardian)

Please return prior to scheduling the evaluation:

- **Fax: 417-627-5542**
- **Email: kim@dstherapy.org**
- **Mail: 2673 E. Sawyer Road Republic, MO 65738**
- **Hand Deliver**

Patient:_____DOB:_____HEIGHT_____WEIGHT_____
Address:_____
Patient Lives With: _____
Diagnosis:_____Date of onset:_____
Medications:_____
Seizure Type:_____ Controlled: Y N Date of Last Seizure_____
Shunt Present: Y N Date of last revision:_____
Special Precautions/Needs:_____
_____
Mobility: Independent Walking Y N Assisted Walking Y N Wheelchair Y N
Braces/Assistive Devices:_____
Complications during pregnancy and/or delivery of Patient:
_____

_____

Please list and date any surgeries the patient has had:_____

_____

_____

Please list any other health care professionals currently treating the patient: _____

_____

_____

School Attended: _____ Grade: _____

*If patient currently has an IEP, please bring most recent copy

Has the patient had previous or current therapy? Yes No *If yes, where:*_____

Type: Speech Occupational Physical Play

*If currently receiving therapy, please bring most recent evaluations/progress reports

Why are you seeking therapy services?_____

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Please indicate current or past difficulties in the following systems/areas:

	Y	N	COMMENTS
Hearing			
Vision			
Sensory Concerns			
Speech			
Cardiac			
Circulation			
Skin			
Immune System			
Lung			
Nervous System			
Muscular/Tone			
Balance			
Orthopedic			
Allergies (Including latex and animal)			
Learning Disability			
Cognition			
Emotional/Psychological			
Pain			
Feeding/Swallowing			
Other			

This form has been completed to the best of my knowledge:

_____/_____/_____

Patient's Parent or Legal Guardian (Print Name) Signature Date

_____/_____/_____

Patient (Print Name) Signature (If over 18 years of age) Date

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