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:** [illegible]
- **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?____