



**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](mailto: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? \_\_\_\_\_



*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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