HISTORY FORM

General Information:

Name: _____ Date of Birth: _____

Address: _____

City: _____ Zip Code: _____

Home/Cell Phone: _____

Marital Status: _____ Age: _____

Occupation: _____ Work Phone: _____

Email Address: _____

Referred By: _____

Primary Doctor: _____ Phone #: _____

Address: _____

Concerns:

Please describe your primary concern(s):

_____

_____

_____

Health and Medical Information:

General Medical:

Primary Care Physician: _____ Telephone: _____

Are you under the care of other medical specialists? _____

If yes, please describe:

_____

_____

_____

Please describe your overall physical health:

Please provide any pertinent medical history including any testing that has been done:

Date	Type	Diagnosis	Recommendations

Head Injury:

Have you ever had a head injury such as a concussion? _____

If yes, please describe (year, treatments):

Seizures:

Have you ever had a seizure? _____
If yes, please describe (frequency, medications):

Medications:

Please list all past and current medications and dosages:

General Health:

Has any of your immediate family member's experienced personal, social or learning problems? _____

If yes, please describe:

Have you ever suffered from a serious or debilitating illness? _____

If yes, please check from any of the following:

		Comments
Respiratory problems	_____	_____
High fever	_____	_____
Meningitis	_____	_____
Ear infections	_____	_____
Throat problems	_____	_____
Asthma	_____	_____
Skin Problems	_____	_____
Stomach Problems	_____	_____
Allergies	_____	_____
Epilepsy	_____	_____
Seizures	_____	_____
Bedwetting	_____	_____
Self-Mutilation	_____	_____

Medical History:

Please check any of the following that apply to you:

- Allergies_____
- Frequent colds _____
- Dizziness _____
- Encephalitis _____
- High Fever _____
- Measles _____
- Pneumonia _____
- Tinnitus _____
- Asthma _____
- Convulsions _____
- Draining ear _____
- German Measles _____
- Influenza _____
- Meningitis _____
- Seizures _____
- Tonsillitis _____
- Chicken pox _____
- Croup _____
- Ear Infections _____
- Head aches _____
- Mastoiditis _____
- Mumps _____
- Sinusitis _____
- Others _____

If you checked any of the above conditions, please explain:

Sensory-Motor Function

Do you have fine motor difficulties? _____
If yes, please describe:

Do you have gross motor difficulties? _____
If yes, please describe:

Hand Preference

Please indicate L, R or A (ambidextrous) for the following tasks:

General _____ Throwing _____

Writing _____ Eating_____

Brushing Teeth _____ Brushing Hair_____

General Behavior

Please use the following scale to describe your overall behavior: Often, Sometimes, Rarely, Never:

Distractible: _____ Cooperative: _____ Short attention Span: _____

Organized: _____ Hyperactive: _____ Disorganized: _____

Hypoactive: _____

High pain tolerance: _____

Low pain tolerance: _____

Tics: _____

Phobias: _____

Impulsive: _____

Inflexible: _____

Low frustration: _____

Overreacts: _____

Few/no friends: _____

Socially immature: _____

Avoidance behaviors: _____

Aggressive: _____

Sound sensitive: _____

Touch sensitive: _____

Odor sensitive : _____

Compliant: _____

Please respond to the follow questions about your general behavior:

How do you typically respond to distractions?

How would you rate your response to difficult tasks?

How would you rate your level of organization?

How would you rate your listening skills?

How would you rate your attention?

Please describe your typical mood?

Person completing form:

_____

Signed: _____ Date: _____