WAUWATOSA THERAPIES, LLC
PEDIATRIC THERAPY SPECIALISTS

Health History Form

CHILD'S NAME: _____ DATE OF BIRTH: _____
PARENT'S NAME: _____
HOME ADDRESS:_____
PHONE NUMBER:_____ E-MAIL: _____

PHYSICIAN'S NAME: _____
PHYSICIAN'S PHONE: _____ FAX:_____
PHYSICIAN'S ADDRESS: _____

PRESENT CONCERNS: _____
_____
MEDICATIONS:_____
_____
ALLERGIES:_____

PREGNANCY & BIRTH
Where was your child born? _____
Any medical problems during pregnancy and / or delivery? If so, please specify:_____
_____
_____
_____
Delivery by: Vaginal birth Caesarean birth
Birth weight: _____

NUTRITION & FEEDING
Has your child had any feeding/dietary problems? No Yes If yes, please specify:
_____
_____
Child's current diet consists of:_____
Please list any food aversions or strong food preferences: _____

SLEEP
How many hrs / night does your child sleep?_____
How many naps does your child take a day, and for how long? _____
_____
Does your child wake up in the middle of the night? No Yes If so, how many times and for how long?_____
What mood is your child in upon waking in the morning?_____

DEVELOPMENT

At what age did your child:
Sit _____ Crawl _____ Walk_____ Say 3-4 words_____ become potty trained _____
Do you have any current concerns on your child's development?_____
_____
_____

PAST MEDICAL HISTORY:

Please describe any major medical problems, hospitalizations or injuries and their dates.
_____
_____
_____
_____
_____

SOCIAL HISTORY:

Name, Age and Relationship of members living within the home of the child:
_____
_____
_____
_____
What are your child's preferred play activities?_____
_____
How does your child show frustration? _____ _____
_____
How does your child calm down from being upset?_____
_____

SCHOOL HISTORY:
Did/does your child attend: preschool school daycare
Name of school / daycare: _____

Any additional information that would assist in the care of your child:_____
_____
_____
_____