



21-14 Newtown Avenue
First Floor
Astoria, NY, 11102
Tel: 718.545.0958

MEDICAL INFORMATION SHEET

PLEASE ANSWER ALL QUESTIONS AS THOROUGHLY AS POSSIBLE SO WE HAVE A BETTER UNDERSTANDING OF YOUR CHILD'S NEEDS.

CHILD'S NAME: _____ M: _____ F: _____

DATE OF BIRTH: _____ AGE: _____

PARENT / GUARDIAN NAME: _____

ADDRESS: _____

PHONE: HOME (____) _____ WORK (____) _____

FAX: _____ E- mail: _____

1. WHAT IS THE CHILD'S DIAGNOSIS:



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2. GIVE MEDICAL / SURGICAL HISTORY:

- HISTORY OF BOTOX/PHENOL INJECTIONS _____

- HISTORY OF INHIBITIVE / SERIAL CASTING (DATES) _____

- HISTORY OF FRACTURES _____

3. WHAT IS THE CHILD'S:

HEIGHT _____

WEIGHT _____

SHOE SIZE WITH BRACES _____ -SHOE SIZE WITHOUT BRACES _____

4. CIRCUMFERENCE MEASUREMENTS OF:

CHEST _____

WAIST _____

THIGH _____



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5. MEDICAL STATUS

- SEIZURES (date of last one) _____

- SCOLIOSIS _____

- HEART PROBLEMS / HYPERTENSION / PAST HEART SURGERIES _____

- LUNGS PROBLEMS _____

- DIABETES _____

- VISION/HEARING _____

-SHUNTS (hydrocephalus) _____

- TRACHEAL/G- TUBE _____

- KIDNEY PROBLEMS _____

-DOES YOUR CHILD HAVE A LEG LENGTH DESCREPNENCY? PLEASE GIVE MEASUREMNT IN CENTIMETERS.

RIGHT LEG _____ LEFT LEG _____

PLEASE PROVIDE NAMES & PHONE NUMBERS TO ALL SPECIALISTS WHO TREAT YOUR CHILD.

1. _____

2. _____

3. _____

4. _____



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5. _____

6. PLEASE LIST ANY MEDICATIONS YOUR CHILD IS CURRENTLY TAKING & REASON FOR TAKING.

7. CHILD ABILITIES (rolling, sitting, crawling, and walking):

**8. LIST OF MEDICAL EQUIPMENT THAT YOUR CHILD IS USING:
(braces, walker, crutches, wheelchair)**



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9. HOW DO YOU COMMUNICATE WITH YOUR CHILD / HOW DO THEY COMMUNICATE WITH YOU?

10. IS YOUR CHILD ABLE TO FOLLOW SIMPLE COMMANDS:

**11. HAVE YOU EVER BEEN DENIED THERAPY AT OTHER THERASUIT CLINIC?
(IF YES, PLEASE EXPLAIN WHEN, WHERE AND WHY)**

12. HAS YOUR CHILD BEEN ADVISED AGAINST EXERCISING?

(IF YES, PLEASE EXPLAIN WHEN, WHERE AND WHY)

13. PLEASE COMMENT BELOW ON YOUR CHILD'S HABITS:

EATING HABITS _____

WATER/FLUID INTAKE _____



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TIME OF DAY THAT YOUR CHILD NAPS _____

PLEASE PROVIDE US WITH A WRITTEN HIP X-RAY REPORT NO OLDER THAN 6 MONTHS

THANK YOU