Celebration Pediatric Physical Therapy

2501 OLD VINELAND RD
SUITE 2501
KISSIMMEE, FL 34746

PO BOX 471086
KISSIMMEE, FL 34747

(407) 734-1012 celebrationppt@gmail.com

MEMBER HEALTH INFORMATION SHEET

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

DATE: _____

CHILDS NAME: _____ M: _____F: _____

DATE OF BIRTH_____ AGE: _____

_

PARENT/GUARDIAN NAME: _____

ADDRESS: _____

_____

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

FAX: (_____) _____

EMAIL: _____

1. WHAT IS YOUR CHILDS DIAGNOSIS?

_____

_____

_____

2. GIVE MEDICAL AND SURGICAL HISTORY.

_____

_____

_____

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HISTORY OF BOTOX/PHENOL INJECTIONS? _____

HISTORY OF INHIBATIVE / SERIAL CASTING? (DATES) _____

3. WHAT IS YOUR CHILDS;

HEIGHT: _____ WEIGHT: _____

SHOE SIZE WITH BRACES: _____

SHOE SIZE WITHOUT BRACES: _____

4. CIRCUMFERENCE OF MEASUREMENTS OF:

HEAD: _____

WAIST: _____

THIGH: _____

5. MEDICAL STATUS

SEIZURES (LAST ONE): _____

SCOLIOSIS: _____

HEART PROBLEMS/HYPERTENSION / PAST HEART SURGURIES: _____

_____

LUNG PROBLEMS: _____

DIABETES: _____

VISION / HEARING: _____

SHUNTS: Hydrocephalus: _____

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DOES YOUR CHILD HAVE ANY LEG DESCRPANCY?
(Please give measurement in centimeters)

RIGHT LEG: _____ LEFT LEG: _____

PLEASE PROVIDE NAMES AND PHONE NUMBERS TO ALL SPECIALIST WHO TREAT YOUR CHILD.

_____

_____

_____

_____

_____

PLEASE LIST ANY MEDICATION YOUR CHILD IS TAKING & REASON.

_____

_____

_____

_____

_____

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

_____

_____

_____

_____

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

_____

_____

_____

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 YOUR EVER BEEN DENIDED THERAPY AT EUROMED OR EUROPEDS CLINIC? IF YES, EXPLAIN WHEN & WHY?

_____

12. HAS YOUR CHILD BEEN ADVISED AGAINST EXERCISE? WHEN & WHY?

_____

_____

13, PLEASE COMMENT BELOW ON CHILDS HABBITS.

EATING: _____

WATER/FLUID INTAKE: _____

TIME OF DAY YOUR CHILD NAPS: _____

******PLEASE PROVIDE US WITH A WRITTEN HIP X-RAY REPORT NO MORE THAN 6 MONTHS OLD******