Little Heroes, LLC
History Form

Date_____

Completed by_____ Relationship to patient_____

Child's Name_____ Date of Birth_____ Age_____

Parent/Guardian'sName_____

Phone_____Mobile phone_____

E-mail_____

Address_____City/State_____Zip_____

Primary Physician_____Phone_____

Address_____

Please list any other specialists your child has seen (orthopedist, neurologist, rehab specialists, etc...)_____

_____

Medical Diagnosis_____

Reason for Referral_____

Birth Information

Complications during pregnancy_____

Gestational age (length of pregnancy)_____birth weight_____Apgar score_____

Type of delivery: vaginal____ C-section____ Breech____ Forceps____ other_____

Complications following delivery: Jaundice____ Breathing____ Heart problems_____

Seizures____ other_____

Child's Medical History:

Pneumonia____ Reflux____ Allergies____ Chicken Pox____ Seizures____

Ear infections (How many)____ Last ear infection_____ Other_____

_____ General Health_____

Medical Procedures/Medications: (Please list dates if applicable)

Ear Tubes_____ Removed?_____ Trach_____ G-tube_____ Shunt_____

Heart Surgery_____ Other_____

_____

Please list any current medications and reason for use:_____

_____

Gross Motor:

Which physical activities does your child enjoy the most:_____

_____

Which activities does your child struggle with the most:_____

_____

Is there any gross motor skills you feel he/she should have mastered by now but have not?___

_____

Social/Behavioral/Self-Care:

Describe your child's independence with "self-care" task (dressing, feeding, etc…)_____

_____

Describe your child's reactions to "sensory input" (touch, noise, visual, movement, etc…)_____

_____

How does your child interact in a social/group setting?

_____

_____

Please list any other interventions your child has received and how well you feel they helped__

_____

_____

Please state any other concerns and what you would like to see your child obtain through therapy_____

_____