

# MEDICAL HISTORY FORM

(to be completed by the parents)

Patient's Name \_\_\_\_\_ Male \_\_\_ Female \_\_\_ Date of birth \_\_\_\_\_

Diagnosis \_\_\_\_\_

Diagnosed at what age: \_\_\_\_\_

If cerebral palsy type: \_\_\_ Spastic diplegia \_\_\_ Quadriplegia \_\_\_ Triplegia \_\_\_ Hemiplegia

- **Pregnancy**

Duration \_\_\_\_\_ weeks

Birth weight \_\_\_\_\_ lbs. \_\_\_\_\_ oz.

Complications \_\_\_\_\_

- **Delivery**

Normal vaginal delivery \_\_\_ yes \_\_\_ no

Caesarian section \_\_\_ yes \_\_\_ no

Forceps \_\_\_ yes \_\_\_ no

Other \_\_\_\_\_

- **Neonatal Problems**

Ventilator \_\_\_ yes \_\_\_ no If yes, how long \_\_\_\_\_

Brain hemorrhage \_\_\_ yes \_\_\_ no If yes, what grade? \_\_\_\_\_

Hydrocephalus \_\_\_ yes \_\_\_ no Was shunt placed? \_\_\_ When? \_\_\_

Shunt revisions \_\_\_ yes \_\_\_ no Dates \_\_\_\_\_

Seizures \_\_\_ yes \_\_\_ no

Other \_\_\_\_\_

- **Diagnostic Tests**

Head CT scan: \_\_\_ yes \_\_\_ no If yes, date \_\_\_\_\_

Head MRI: \_\_\_ yes \_\_\_ no If yes, date \_\_\_\_\_

Hip X-ray: \_\_\_ yes \_\_\_ no If yes, date \_\_\_\_\_

Back X-ray \_\_\_ yes \_\_\_ no If yes, date \_\_\_\_\_

- **Surgery History:**

Please indicate month and year of surgery

Gastrocnemius/heelcord \_\_\_\_\_

Derotation osteotomy \_\_\_\_\_

Adductors \_\_\_\_\_

Hamstrings \_\_\_\_\_

Other \_\_\_\_\_

\_\_\_\_\_

Has your child ever had Botox or Phenol injections? \_\_\_ yes \_\_\_ no If yes, please list muscles and, the dates they were injected & the results \_\_\_\_\_

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Current Medications \_\_\_\_\_

Medical Problems, including allergies \_\_\_\_\_

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**GENERAL DEVELOPMENT**

- How do you communicate with your child? \_\_\_\_\_
- Can your child follow simple commands? \_\_\_\_\_
- What is your child's hearing and vision? \_\_\_\_\_

**Child's Current Abilities:**

At what age did your child first:

Sit alone on the floor	_____	Sit alone on bench	_____
Creep on hands and knees	_____	Get into sitting	_____
Pull to stand	_____	Stand alone	_____
Walk with an assistive device	_____	Walk alone	_____

**LEVEL OF FUNCTIONAL MOBILITY (Circle current level achieved)**

- Functional independent ambulation, all environments
- Independent ambulation, protected environments
- Functional ambulation, crutches/canes, all environments    \_\_\_\_ crutches    \_\_\_\_ canes
- Ambulation, crutches/canes, protected environments    \_\_\_\_ crutches    \_\_\_\_ canes
- Functional ambulation, walker, all environments
- Ambulation, walker, protected environments
- Crawling, reciprocating arms and legs
- Some method of independent mobility, unassisted commando crawling or rolling
- No independent floor mobility or walking

Lower extremity bracing    \_\_\_\_ yes    \_\_\_\_ no    Type \_\_\_\_\_

List of Medical Equipment that your child is using (walkers, wheelchairs, etc...)

\_\_\_\_\_

What are your goals for your child? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What does your child enjoy?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Any additional information you would like to share? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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