Medical History Questionnaire

Patient's Name: ______________________________ Birthdate:_____________

Person Completing Form and relationship to Patient: ______________________________

Parents/legal guardians please circle: Biological Child Adopted Child Foster Child

Gender: ________________

Emergency Contact (name, relationship, number):______________________________

Diagnosis: ______________________ Date of Onset:______________________

Concerns:

1.____

2.____

3.____

4. ____

Social History

Adult Patients-

Others in your home (Family members, roommates):______________________________

____

Current and previous occupations: ______________________________

____

Preferred past times/hobbies: ______________________________

____

Have you received therapy services in the past? Where and when?____________________

____

Pediatric Patients-

Others in child's home (parents, guardians, siblings) ____

____

Does child attend daycare and/or school? Where? ____

Grade in school: _________________________

Has your child received therapy services in the past? YES NO

Where and When? ____

Does your child receive any support services at school/home? ___________________________

Pain-

Is the participant currently experiencing any pain? YES NO

Where is the pain located?____

Can you describe the pain? (Constant/intermittent? Type?)_________________________________

Is the participant medically fit and able to participate in equine based activities? YES NO

Medical History-

Surgeries/Hospitalizations: ____

____

Previous Diagnosis: ____

____

Current Medications: ____

____

Allergies:____

____

Specialists being seen/has been seen: ____

____

Medical equipment/Orthotics: ____

Immunizations Current: YES NO

Is the participant able to hold their head upright and in midline? YES NO

For how long? Less than 1 minute 2-5 minutes 5-15 minutes 15-30 minutes 30+

Is the participant able to sit independently? YES NO

Does the participant have a history of seizures? YES NO

If yes, how frequent, what type, what are the triggers, and how are they currently being managed?

____

When was the last one? ____

Does the participant have a history of subluxations or dislocations?___________________________

Is there any additional information you feel is important for the therapist to know prior to beginning therapy? ____

____

____