



Dumas Therapy

3203 B Vineville Avenue. Macon, Georgia 31204
Office: (478) 737-9759 Fax (478) 475-1010

Patient Medical History

Child's Name: _____

Date of Birth: _____

Diagnosis: _____

Who may we thank for referring you? _____

Your child's physician(s) _____

Brief description of therapeutic concerns about your child:

BIRTH HISTORY:

Describe any illnesses or injuries during pregnancy: _____

During pregnancy did mother: Smoke ___ Yes ___ No Use drugs? ___ Yes ___ No

Use alcohol? ___ Yes ___ No; Quantity/Frequency: _____

Was birth delivery normal? ___ Yes ___ No Premature? ___ Yes ___ No

How much premature? _____

Length of labor: _____ Birth weight: _____

Describe problems that may have been encountered during labor:

Was the baby: Jaundiced? ___ Yes ___ No

Needed oxygen? ___ Yes ___ No

Needed an incubator? ___ Yes ___ No

Describe feeding problems: _____

Food allergies: _____

HEALTH:

List all doctors your child has seen:

List **ALL** of your child's medications. Include prescription drugs, hormone therapy, over the counter drugs, herbal remedies, and vitamins:

List all operations your child may have underwent:

Has your child ever had: (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Problems hearing | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Choking at meals | <input type="checkbox"/> Coughing at or during meals |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Heartburn or reflux |
| <input type="checkbox"/> Changes in voice quality | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Head injury with loss of consciousness | <input type="checkbox"/> Weight loss |
| <input type="checkbox"/> Head injury without loss of consciousness | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Repeated pneumonia | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> German Measles | <input type="checkbox"/> Meningitis |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Fevers over 104 | <input type="checkbox"/> Anxieties/fears |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Chemical exposure |
| <input type="checkbox"/> Sinus infections | <input type="checkbox"/> Cleft lip or palate |
| <input type="checkbox"/> Flu | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Broken bones |
| <input type="checkbox"/> History of drug or alcohol abuse | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Immune problems |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Encephalitis |
| <input type="checkbox"/> Fullness or pressure in the ears | <input type="checkbox"/> Dizziness/vertigo |

Exposed to loud noises Ever worn hearing aids
 Other: _____
 Syndromes: _____
 Allergies: _____

Are your child's immunizations current? Yes No

What other services have your child received? (Check all that apply)

Physical therapy Occupational therapy
 Chiropractic treatment Counseling services
 Massage therapy Psychiatry
 Respiratory therapy Academic testing
 Other: _____

Does your child have a current IEP? _____

School's Name: _____

Is your child currently receiving therapy services at school?

IEP Case Manager or LEA's name:

May we contact them? yes no

Child's Grade: _____