Sparrow

Medical History and Subjective Information Form
Orthopedic/Casting/Scar Treatment

Please answer the following questions. If you need help filling out this form, we would be happy to assist you.

Patient Name_____ Birth Date: _____ Today's Date: _____

Past Medical History

☐ Fracture _____	☐ Limb Deficiency	☐ Scoliosis
☐ Sprain _____	☐ Club Foot	☐ Hip Dysplasia
☐ Acquired Amputation	☐ Club Hand	☐ Dog-Bite
☐ Congenital Amputation	☐ Intoeing	☐ Burn
☐ Kyphosis	☐ Outtoeing	☐ Arthrogryposis
☐ Bone Tumor	☐ Toe Walking	☐ Other:_____

Surgeries or Procedures: _____

_____

Physicians Currently Active in your Child's Care:

Name/Date	Name/Date
Family Doctor:	Plastic Surgeon:
Orthopedist:	Physical Therapist:
Orthopedic Surgeon:	Occupational Therapist:
Orthotist:	Speech Therapist:
Physiatrist:	Other: _____

Diagnostic Test: Has your child had any of the following?

Test	Date/Result	Test	Date/Result
X-ray		MRI	
CT Scan		Other: _____	

Please Check all of the following boxes that apply

☐ 1 story house with/without basement	☐ Stairs to enter home/apartment
☐ 2 story house with/without basement	☐ Railing on stairs __1 ___2
☐ Apartment	☐ Walk-in shower
☐ Mobile Home	☐ Tub/Shower Combination

Child Lives with: ☐ Mother ☐ Father ☐ Grandmother ☐ Grandfather ☐ Foster Parents ☐ Aunt ☐ Uncle ☐ Brother(s) #__
☐ Sister(s) #__ ☐ Step-mother ☐ Step-father ☐ In Residential Facility ☐ Other_____

Previous Therapy:	Yes	No		Yes	No
Early-On Physical Therapy	☐	☐	School Physical Therapy	☐	☐
Early-On Occupational Therapy	☐	☐	School Occupational Therapy	☐	☐
Early-On Speech Therapy	☐	☐	School Speech Therapy	☐	☐

Name Of Therapist: _____

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