

Therapy Solutions for Kids

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MEDICAL INFORMATION

Name of Patient:		
Date of birth:	Age:	Gender: M or F
Primary care physician:		
DIAGNOSIS (if known):		
Birth History:(brief summary)		
Has your child had any surgeries? YES NO: Describe:		
Medical Conditions: (seizures; G-tube; ear infections; etc)		
Current Medications:		
Allergies:		
Recent Hospitalizations:		
Other recent tests: (such as MRI; CT Scan: swallow study; X-rays, hearing test; etc.)		
Other Physician's or Community Therapists your child may see or have seen:		
Name:	Phone:	