PATHWAYS
animal assisted therapy, inc.

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CLIENT'S MEDICAL HISTORY

Name: ____ Date: ______________
D.O.B.: ___/___/___ Age: ______ Sex: ______ Height:______ Weight: ______ Pulse:______ B.P.: _____
Diagnosis: ____
Diagnostic code: ____
Cause: ____
Medications (type, purpose, dose): ____
____
If Downs Syndrome, Atlanto-Axial Subluxation? ☐ Yes ☐ No
Cervical X-Ray for Atlanto-Axial Subluxation: ☐ Positive Negative X-Ray date:______________

Please indicate if the client has or has had a history of the following secondary problems by checking yes or no. If YES, please include COMPLETE information pertaining to the problem.

PROBLEM	YES	NO	IF YES, OR HISTORY OF, PLEASE DESCRIBE
Auditory Impairment	☐	☐	______________________
Attention Deficit Disorder	☐	☐	______________________
Attention Deficit Hyperactivity Disorder (ADHD)	☐	☐	______________________
Hyperactivity	☐	☐	______________________
Learning Disability	☐	☐	______________________
Mental Impairment	☐	☐	______________________
Psychological Impairment	☐	☐	______________________
Speech Impairment	☐	☐	______________________
Visual Impairment	☐	☐	Glasses: ______________
Allergies	☐	☐	______________________
Cardiac	☐	☐	______________________
Circulatory	☐	☐	______________________
PVD	☐	☐	______________________
Postural Hypotension	☐	☐	______________________
Hemophilia	☐	☐	______________________
Pulmonary	☐	☐	______________________
Asthma/COPD	☐	☐	______________________
Neurological	☐	☐	______________________
Seizures	☐	☐	______________________
Controlled	☐	☐	Type: ______________
Date of last seizure:	____/____/____		
Hydrocephaius	☐	☐	______________________
Shunt	☐	☐	Number of revisions: ______________
Sensory Loss	☐	☐	______________________
Pain	☐	☐	______________________

PROBLEM	YES	NO	IF YES, OR HISTORY OF, PLEASE DESCRIBE
Muscular	☐	☐	______
Contractures	☐	☐	______
Skeletal	☐	☐	______
Spinal Column Injury	☐	☐	______
Subluxing Joints	☐	☐	______
Dislocating Joints	☐	☐	______
Laminectomy/Fusion	☐	☐	______
Scoliosis-Degree/Type/ Brace/Last x-ray	☐	☐	______
Kyphosis/Lordosis	☐	☐	______
Degree/Type	☐	☐	______
Spondylolisthesis	☐	☐	______
Spinal Abnormality	☐	☐	______
Osteoporosis	☐	☐	______
Heterotrophic Ossification	☐	☐	______
Joint Disease	☐	☐	______
Cranial Defects	☐	☐	______
Fractures	☐	☐	Location/healed? ______
Other	☐	☐	______

MEDICAL HISTORY

Please indicate any medical problems not indicated above:______

______

______

______

Please indicate special precautions: ______

______

______

______

MOBILITY STATUS

Is the student ambulatory? ☐ Yes ☐ No Can the student ambulate independently? ☐ Yes ☐ No

If no, please describe: ______

PROSTHETICS/ORTHODONTICS:

Type: ______ Purpose: ______

Type: ______ Purpose: ______

Please describe any other additional information that might help us to work with this student.

______

______

______

______

Physician's Signature: ______ Date:______

Physician's Name (Please Print): ______

Physician's Address: ______

City:______ State: ______ Zip:______

Phone: ______