Parent Health and Medical History Form

Participant Name:_____

Diagnosis:_____
_____

Please complete the following which addresses special needs and/or concerns to bring to our attention:

| | YES | NO | COMMENTS |
|---|---|---|---|
| VISION | | | |
| HEARING | | | |
| SENSATION | | | |
| COMMUNICATION | | | |
| HEART | | | |
| BREATHING | | | |
| DIGESTION | | | |
| CIRCULATION | | | |
| EMOTIONAL | | | |
| BEHAVIORAL | | | |
| PAIN | | | |
| BONE/JOINT | | | |
| MUSCULAR | | | |
| COGNITION/THINKING | | | |
| NEUROLOGICAL | | | |
| DOWN SYNDROME | | | |
| LEARNING DISABILITIES | | | |
| (SPECIFY) | | | |
| OTHER | | | |

Describe abilities/difficulties in the following areas (include assistance required or equipment needed)

Functional (ie mobility skills such as transfers, walking, wheelchair use, driving, bus riding)

_____
_____
_____

SOCIAL (ie Work/school including grade completed, leisure interests, relationships-family structure

_____

_____

_____