



SAN ANTONIO BUSY BODIES
A Non-Profit Motor Behavior Program
11985 Starcrest
San Antonio, Texas 78247
(210) 545-2840

MEDICAL, DEVELOPMENTAL, AND EDUCATIONAL HISTORY

Child's Name: _____ Age: _____ Birthdate: _____

Parent's Names: _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip Code: _____

Father's Place of Employment: _____

Work Phone: _____ Father's email _____

Mother's Place of Employment: _____ Work Phone: _____

Work Phone: _____ Mother's email _____

Have Natural Parent's Been Separated or Divorced? Yes No

If Yes, Who has Custody of the Child? _____

Name of School: _____ Grade: _____

Teacher's Name: _____

Referred by: _____

Physician Referral: _____

Indicate the Primary Reason for this Referral: _____

Have any other family members experienced the same difficulty described above? If Yes, Explain. _____

MEDICAL HISTORY

If your child has ever experienced any of the following, please check those items. For areas needing more explanation, include this in the space provided.

<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Visual Impairment	<input type="checkbox"/>	Serious Injury
<input type="checkbox"/>	Ear Infections	<input type="checkbox"/>	Wears Corrective lens	<input type="checkbox"/>	Serious illness
<input type="checkbox"/>	Speech problems	<input type="checkbox"/>	Hearing impairment	<input type="checkbox"/>	Braces or bars
<input type="checkbox"/>	Learning disability	<input type="checkbox"/>	Emotional problems	<input type="checkbox"/>	Corrective shoes
<input type="checkbox"/>	ADHD/ADD	<input type="checkbox"/>	Behavioral problems	<input type="checkbox"/>	Unusual sleep habits
<input type="checkbox"/>	Taking medication	<input type="checkbox"/>	Cerebral Palsy	<input type="checkbox"/>	High fevers
<input type="checkbox"/>	Neurological problems	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	Orthopedic problems	<input type="checkbox"/>	Spasticity	<input type="checkbox"/>	Other problems
<input type="checkbox"/>	Muscular coordination problems				

Explanation: _____

WHAT SPECIALISTS HAVE EXAMINED YOUR CHILD?

	Name	Date	Results
Neurologist			
Family Physician			
Pediatrician			
Ophthalmologist			
Ear/Nose/Throat			
Allergist			
Psychiatrist			
Physical Therapist			
Occupational Therapist			
Other			

