



FIELDSTONE FARM

P.O Box 23129
 Chagrin Falls, Ohio 44023
 Phone: 440-708-0013

Medical History

(Please complete all portions of this form)

Name _____ Date of Birth _____
 Address _____ City _____ Zip _____
 Male / Female _____ Name of Parent / Guardian _____
 Referred by _____ Relationship _____ Phone # _____
 Reason for Referral _____

Diagnosis _____ Date of Onset _____
 Tetanus Shot: Yes/No Date _____ Height _____ Weight _____
 Seizure Type _____ Controlled? Yes / No Date of last seizure _____
 Medications _____

Mobility: (Circle each) Ambulatory? Yes/No Crutches? Yes/No
Braces? Yes/No Wheelchair? Yes/No

| <u>AREAS</u> | Has Involvement | <u>COMMENTS</u> |
|--|-----------------|-----------------|
| Auditory | | |
| Visual | | |
| Speech | | |
| Cardiac | | |
| Circulatory (incl. hemophilia) | | |
| Pulmonary | | |
| Neurological | | |
| Muscular | | |
| Orthopedic (incl. spinal/ joint abnormal.) | | |
| Allergies (incl. asthma, food, insect stings) | | |
| Learning Disability | | |
| Mental Impairment | | |
| Psychological Impair. (incl. behavioral) | | |
| Other (ie: shunt, sensory loss, feeding tube, etc) | | |

Continued on next page

How does participant respond to:

- ❖ Transition, New situations: _____

- ❖ Animals: _____

- ❖ Human touch: _____

- ❖ Frustration: _____

- ❖ Fear: _____

- ❖ Other: _____

Please describe:

- ❖ Potential motivators: _____

- ❖ Behavioral modification techniques: _____

- ❖ Any safety concerns there might be with self, others or animals: _____

- ❖ How much supervision participant needs: _____

- ❖ De-escalation strategies used: _____

- ❖ Goals for this participant: _____

Any other comments:

Name of person completing this history: _____

Relationship to participant: _____

Date: _____