# Courage Center – Intensive Therapy Model

TheraSuit Method®

## MEMBER INFORMATION SHEET

CHILD'S NAME: ______________________________ M: ______ F: ______

DATE OF BIRTH: ______________________ AGE: ____________________

PARENT / GUARDIAN NAME: ________________________________________

ADDRESS: ______________________________________________________

_______________________________________________________________

PHONE: HOME (_____)_________________ WORK (_____)_________________

FAX: (_____)____________________

EMAIL: ___________________________________

1. WHAT IS THE CHILD'S DIAGNOSIS?

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

2. GIVE MEDICAL / SURGICAL HISTORY:

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

HISTORY OF BOTOX/PHENOL INJECTIONS: ___________________________

HISTORY OF INHIBITIVE / SERIAL CASTING (DATES) ____________________

HISTORY OF FRACTURES: ______________________________________________

3. THE CHILD'S

HEIGHT: ____________________

WEIGHT: ____________________

4. CIRCUMFERENCES OF

CHEST: _____________________

WAIST: _____________________

THIGH: _____________________

5. MEDICAL STATUS

SEIZURES (Date of last one) _______________________________________

SCOLIOSIS _____________________________________________________

HEART PROBLEMS / HYPERTENSION / PAST HEART SURGERIES __________

_____________________________________________________________________

LUNG PROBLEMS _________________________________________________

DIABETES ______________________________________________________

VISION / HEARING _______________________________________________

SHUNTS (Hydrocephalus) __________________________________________

TRACHEAL / G-TUBE ______________________________________________

KIDNEY PROBLEMS _______________________________________________

PLEASE PROVIDE PHONE NUMBERS TO ALL SPECIALISTS WHO TREAT YOUR CHILD.

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

6.) PLEASE LIST ANY MEDICATIONS YOUR CHILD IS CURRENTLY TAKING (and reason for taking)

_____________________________________________________________________

_____________________________________________________________________

7.) CHILD'S ABILITIES (rolling, sitting, crawling and walking):

8.) LIST OF MEDICAL EQUIPMENT THAT YOUR CHILD IS USING:
(braces, walker, crutches, wheelchair)

9.) HOW DO YOU COMMUNICATE WITH YOUR CHILD / HOW DO THEY COMMUNICATE WITH YOU?

10.) IS YOUR CHILD ABLE TO FOLLOW SIMPLE COMMANDS?

11.) HAVE YOU EVER BEEN DENIED THERAPY AT EUROPEDS OR EUROMED CLINIC?
IF YES, PLEASE EXPLAIN (WHEN AND WHY).

12.) PLEASE PROVIDE US WITH WRITTEN HIP X-RAY REPORT (NO OLDER THAN 6 MOS.)

**PLEASE MAIL OR FAX COMPLETED FORM TO**:

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