

THERAPEUTIC SERVICES AGENCY, INC.

220 Railroad St. SE · PINE CITY, MN 55063 · (320) 629-7600 · DEPOT FAX (320) 629-7900 · HILLTOP FAX (320-629-0003)

HEALTH HISTORY

TO BE PROMPTLY COMPLETED BY PARENT & RETURNED TO THERAPEUTIC SERVICES AGENCY.

Name of child _____ D.O.B. _____

Parent's name _____ Phone _____

Address _____

Family Physician _____ Phone _____

CHECK, GIVING APPROXIMATE DATES OF PAST ILLNESSES, IF POSSIBLE

Frequent colds	_____	Fever	_____
Frequent sore throats	_____	T.B.	_____
Sinuses-asthma	_____	Seizures	_____
Ear problems	_____	Chicken pox	_____
Chest problems	_____	Measles	_____
Diabetes	_____	Mumps	_____
Kidney problems	_____	Whooping cough	_____
Heart problems	_____	Athlete's foot	_____

IMMUNIZATIONS RECORD DATES OR WRITE "NONE" IN BLANK.

Diphtheria	_____	Polio	_____
Smallpox	_____	T.B.	_____
Whooping cough	_____	Typhoid	_____
Tetanus toxoid	_____		

Recent exposure to contagious disease? _____

Any physical restrictions? _____

Past operations or illnesses? _____

Presently on medication (list)? _____

Any special dietary or medical routines to be followed? Be specific. _____

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PHYSICAL EXAMINATION

Patient's Name: _____ D.O.B. _____

Height _____ Vision R 20/ _____ With glasses R 20/ _____
Weight _____ Vision L 20/ _____ With glasses L 20/ _____
B.P. _____

Eyes	_____	Abdomen	_____
Ears	_____	Hernia	_____
Hearing	_____	Reflexes	_____
Nose	_____	Speech	_____
Throat	_____	Pilonidal sinus	_____
Teeth	_____	Genitalia (maturity)	_____
Thyroid	_____	Extremities (joints)	_____
Lymph Nodes	_____	Skeletal (scoliosis)	_____
Chest	_____	Skin (acne/scars)	_____
Heart	_____	Emotional adjustment	_____
Lungs	_____		

Should be restricted from _____

Individual is susceptible (or allergic) to: _____

Other instructions: _____

PHYSICIAN'S ASSESSMENT

This person appears to be fit to participate in:

Outdoor sports _____ Water sports _____ Competitive sports _____

Date _____ Signature _____
(Physician licensed to practice medicine)

Address _____

PLEASE RETURN A COPY OF BOTH SIDES TO THERAPEUTIC SERVICES AGENCY. THANK YOU.

MA # _____

Bill to: _____

Address: _____