THERAPEUTIC SERVICES AGENCY, INC.

220 Railroad St. SE · PINE CITY, MN 55063 · (320) 629-7600 · Fax (651) 925-0071

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

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: ______________________________