REVIVO
NEUROLOGY TREATMENT CENTRE

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# SUIT THERAPY PROGRAMME

## PROGRAMME MEMBER INFORMATION SHEET

CHILD'S NAME: ____________________________________________________________

M: ______ F: ______ DATE OF BIRTH: ______________________________ AGE: ____________________________

PARENT/GUARDIAN NAME: ____________________________________________________________

ADDRESS: ____________________________________________________________

____________________________________________________________

PHONE (WITH AREA CODE): HOME ______________________________ WORK ______________________________

CELL ____________________________ E-MAIL: ____________________________________________________

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. What is the child's: - Height ____________________ - Weight ____________________

4. Circumferences of:

- Chest ______________________

- Waist ______________________

- Thigh ______________________

5. Shoe size: __________________

6. Medical status

- Seizures (date of last one): ________________________________________________

- Scoliosis: _____________________________________________________________

- Heart problems / Hypertension / Past heart surgeries: _______________________________

______________________________________________________________________________

- Lungs problems: _________________________________________________________

- Diabetis: ______________________________________________________________

- Vision/Hearing: _________________________________________________________

- Shunts (hydrocephalus): ___________________________________________________

- Tracheal/G-Tube: ________________________________________________________

- Kidney problems: ________________________________________________________

Please provide phone numbers to all specialists who treat your child:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

________________________________________________________________________

7. PLEASE LIST ANY MEDICATIONS YOUR CHILD IS CURRENTLY TAKING (AND REASON FOR TAKING):

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

8. CHILD ABILITIES (ROLLING, SITTING, CRAWLING AND WALKING):

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

9. LIST OF MEDICAL EQUIPMENT THAT YOUR CHILD IS USING (BRACES, WALKER, CRUTCHES, WHEELCHAIR):

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

10. HOW DO YOU COMMUNICATE WITH YOUR CHILD / HOW DOES THE CHILD COMMUNICATE WITH YOU?

________________________________________________________________________

________________________________________________________________________

11. IS YOUR CHILD ABLE TO FOLLOW SIMPLE COMMANDS?

________________________________________________________________________

12. PLEASE PROVIDE US WITH WRITTEN HIP X-RAY REPORT (NOT OLDER THAN 6 MONTHS)

13. GOALS AND EXPECTATIONS (PATIENT'S/PARENT'S):

________________________________________________________________________

________________________________________________________________________

PLEASE MAIL OR EMAIL COMPLETED FORM TO OUR HEAD OFFICE AT:

REVIVO NEUROLOGY TREATMENT CENTRE
525 MARKHAM ROAD, SUITE 4
TORONTO, ONTARIO M1H 3H7, CANADA
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