Medical History

Name: _____ **DOB:** _____

Address: _____

Phone: _____ **Cell:** _____

Email: _____

Skype Account: _____

Diagnosis (if any): _____

Medications (if any): _____

Please answer the following questions yes/no and explain "yes" answers:

Do you have any history of premature birth?

Do you have any history of ear infections or loss of hearing?

Do you have any history of Head Injury?

Do you have any history of Stroke?

Do you have any activity limitations?