Children's Therapy Center

Physical Therapy

Today's Date: _____ /_____ /_____

Child's Name: _____

Date of Birth: _____ /_____ /_____ Height: _____ ' _____ " Weight: _____ lbs

How did you hear about us? _____

Emergency Contact: _____

Emergency Contact Phone: (_____)_____-_____ Emergency Contact Relationship: _____

Non-English language(s) spoken at home: _____

First names and ages of siblings: _____

Does your child use any equipment or orthotics? _____

Has your child ever received any other therapy or services? (occupational therapy, speech therapy, counseling, etc.) _____

Illnesses currently being treated: _____

_____

Medications presently taken: _____

_____

FOR SCHOOL AGE CHILDREN

School name: _____ Grade: _____

List any extra-curricular activities, clubs, lessons, etc.: _____

_____

What are a few of your child's interests and hobbies? _____

_____

PREGNANCY

Mother's age at time of birth: _____

Complications:

Vomiting	☐ Yes ☐ No	Threatened miscarriage	☐ Yes ☐ No
Excessive blood loss	☐ Yes ☐ No	Toxemia	☐ Yes ☐ No

Physical Therapy (continued)

PREGNANCY (continued)

Infections: _____

Surgeries: _____

Other illnesses: _____

Smoking during pregnancy? ☐ Yes ☐ No Number of cigarettes per day: _____

Alcohol during pregnancy? ☐ Yes ☐ No Describe: _____

Medications or other drugs during pregnancy: _____

LABOR

Duration of labor: _____ Circle one: Spontaneous / Induced

Type of delivery: Vertex (normal) / Breech / Caesarean

Birth weight: _____ lbs _____ oz

Gestational age: _____ weeks

Complications:

Cord around neck ☐ Yes ☐ No

Hemorrhage ☐ Yes ☐ No

Injury during delivery: _____

Other (specify): _____

Respiration: Immediate / Delayed How long? _____

Cry: Immediate / Delayed How long? _____

NICU Stay ☐ Yes ☐ No How long? _____

Mucus accumulation ☐ Yes ☐ No

Jaundice ☐ Yes ☐ No

Cyanosis (turned blue) ☐ Yes ☐ No

Incubator care ☐ Yes ☐ No How long? _____

Suck: Strong / Weak

Other complications: _____

Physical Therapy (continued)

MEDICAL HISTORY

Check either yes or no and specify the approximate age:

	Yes	No	Age		Yes	No	Age
Autism				Immunization reactions			
Allergies				Genetic disorder			
Birth complications			--	High fevers			
Behavioral problems				Hospital stays			
Childhood illnesses				Orthopedic injuries			
Convulsions (seizures)				Restrictive diet			
Ear/hearing problems				Surgeries			
Eye/vision problems				Swallowing problems			
Head injuries				Other:			

If yes to any of the above, explain: _____

_____

_____

DEVELOPMENTAL MILESTONES

To your best knowledge, indicate the age at which your child reached the following milestones. If you cannot recall the exact age, check the approximate time.

	Age	Early	Normal	Late
Smiled				
Rolled to stomach				
Sat without support				
Crawled				
Stood holding onto something				
Stood without support				
Walked without assistance				
Run				
Climbed stairs without assistance				
Jump with both feet together				
Rode tricycle				
Rode bicycle (without training wheels)				
Skipped				

Physical Therapy (continued)

In your own words, please explain why your child needs physical therapy and state what you would like them to accomplish:

If there is any other information or concerns you would like to share, please do so here: