PREGNANCY/BIRTH HISTORY

Length of pregnancy: ____

List any medications taken during pregnancy: ____

____

Did the mother experience any complications during pregnancy? __________________________

____

Weight at birth? ______________________ APGAR Score (if known) _______________________

Place of birth: ____

Birth conditions (circle applicable): Vaginal C-Section Breech Forceps

Did your baby spend time in NICU? Yes _____ No _____ How long? ___________________

Reason for referral/diagnosis: ____

____

CURRENT CONCERNS

Please describe in detail your primary concerns and overall goals for your child for physical therapy, and any questions you would like answered through the evaluation:

____

____

____

MEDICAL HISTORY/THERAPY CONCERNS

Primary care physician: _____________________________________ Phone: _______________

Other specialists involved: ___________________________________ Phone: _______________

Please list any surgeries, with date of surgery and reasoning **IF** applicable: __________________

____

____

Has your child's vision been evaluated? Yes _____ No _____

If so, when and where? ____

Results? ____

Has your child's hearing been evaluated? Yes _____ No _____

If so, when and where? ____

Results? ____

History of any ear infections? ____

Has your child had medical/surgical treatment for ears? Yes _____ No _____

If so, when and why? ____

Any significant illnesses, infections or hospital stays? Yes _____ No _____

If yes, please describe: ____

____

____

Please list any medications or allergies: ____

Has your child been in therapy before? _________________

If so, please select which discipline: (circle) Occupational Physical Speech ABA

What clinic did they go to before, and when? ____

____

____

Do you feel your child made progress? ____

What worked well, and what didn't? ____

What are your goals and expectations for you child for physical therapy? ___________________

____

____

Does your child experience any of the following (circle all that apply):

Frequent falls Clumsiness Difficulty jumping Bruises easily

Ear infections Weakness Incoordination Pain Food allergies

DEVELOPMENT (disregard if your child suffered a specific injury)

At what approximate age did your child:

_____ Roll from stomach to back

_____ Roll from back to stomach

_____ Crawl

_____ Sit alone without support

_____ Cruise along furniture

_____ Stand alone

_____ Walk Alone

INJURY HISTORY

How did your child become injured? ____

How long ago did injury occur? __________ Is there pain? Yes _____ No _____

If yes, rate pain (circle): 0 1 2 3 4 5 6 7 8 9 10

What is this injury preventing your child from doing? __________________________________

____

Additional information: ____

____

____

SCHOOL HISTORY

Where does your child attend school or daycare? ___________________________________

What grade? ___________ Does your child receive therapy through school? Yes _____ No _____

If yes, what services are provided? ____

ADDITIONAL INFORMATION

Please include any information that you feel would be helpful to therapist treating your child.

____

____

____

____