PATIENT INFORMATION

Child's Name: _____ Date of Birth: _____

Address: _____ Phone: _____

_____ Zip:_____ School: _____

Parent/Caregiver's Name: _____ Date of Birth: _____

Occupation: _____ SSN: _____

Phone: (mobile) _____ (work) _____

Email Address: _____

Parent/Caregiver's Name: _____ Date of Birth: _____

Occupation: _____ SSN: _____

Phone: (mobile) _____ (work) _____

Email Address: _____

Emergency Contact: _____ Phone: _____

Relationship to patient: _____

Other Children/Adults in Home:

Name	Age	Relationship

Primary home language: _____

Other languages spoken in home: _____

Reason for referral / Primary concern: _____

How did you find us? Physician Friend Insurance Internet School Other_____

Person responsible for payment: _____

HEALTH HISTORY

Person Completing History: _____ Relationship to Patient: _____

Prenatal and Birth History

During this pregnancy and/or delivery, did mother or baby experience any complications? If so, please describe.

_____

_____

Length of pregnancy: _____ Birth Weight: _____

Has your child ever been hospitalized? Yes No *If yes*, when and describe: _____

_____

_____

Has your child had any other significant illnesses, injuries, or surgeries? *If yes*, when and describe:

_____

_____

Child's current medications: _____

Please list any specific food, medicinal, or environmental allergies:

_____

_____

Illnesses	Age	Severity	Developmental Changes
Pneumonia			
Influenza			
Asthma			
Encephalitis			
Meningitis			
Whooping Cough			
Allergies			
High Fever (104+)			
Ear Infections			
Seizures			
COVID-19			

Prior Evaluations

	Date	*Results*
Speech/Language	_____	_____
Occupational Therapy	_____	_____
Physical Therapy	_____	_____
Hearing	_____	_____
Vision	_____	_____
Neurological	_____	_____
Psychological	_____	_____
Other	_____	_____

Please provide previous evaluation reports from other professionals or provide facility and/or name of evaluator to request records. This information may be helpful in assessing and planning of treatment for your child.

Is there any additional information that will help us to better understand your child?

_____
_____
_____
_____

DEVELOPMENTAL HISTORY

Was/Does/Can Your Child?	Yes	No	Comments
“Floppy” as an infant?			
“Stiff” as an infant?			
Place one foot on each step when ascending the stairs?			
Place one foot on each step when descending the stairs?			
Need a railing and/or hold an adult’s hand when using stairs?			
Report being dizzy or afraid of using the stairs or ladders on playground equipment?			
Roll to either side to transition from lying on his/her back to sitting up?			
Complete a “sit-up” without help?			
Walk on his/her tiptoes frequently?			
Catch a ball thrown from 5 feet away?			
Catch a ball thrown from 10 feet away?			
Throw a ball to a target 5 feet away?			
Throw a ball to a target 10 feet away?			
Buckle self into a car seat or seat belt?			
Play hopscotch without help?			
Hop on one foot without help?			
Skip rope?			
Skip. alternating the leading leg with each skip?			
Limp when walking?			

Was/Does/Can Your Child?	Yes	No	Comments
Limp when running?			
Bump into walls or objects in the environment when walking?			
Jump down from the curb or a step?			
Jump over an object 4 inches in height?			
Jump over an object 6 inches in height?			
Jump using both feet at the same time?			
Kick a ball without holding onto a wall or support to keep his/her balance?			
Safe when playing on a playscape or playground equipment?			
Maintain pace with peers his/her age during walking and running tasks?			
Work together with peers to carry an object from one point to another?			
Broken any bones or sprained any joints?			
Wear any orthotics or use any braces?			

Please see next page for additional developmental history section.

Complete as appropriate:

Milestone	Typical Age Attained	Actual Age Attained
Head control	4 months	
Log roll	4-6 months	
Segmental rolling	6-8 months	
Independent sitting	8 months	
Creeping	9 months	
Cruising	10 months	
Walking	12 months	