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? Select one: Physician Referral Name/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?

_____

_____

_____

_____

PT New Patient Intake Form

Patient Name:		DOB:	
Reason for Referral/Visit:			
Birth History (how many weeks gestation, birth weight, and method of birth)			
Any Prior History of Hospitalization, Surgery, or Injury?			
Any concerns with nutrition, swallowing, or speech? Seeing SLP?			
Any concerns with dressing or fine motor activities? Seeing OT?			
Home Information	**Stairs** ◯ YES ◯ NO → **Handrail?** YES ◯ NO ◯ **Which side?** RIGHT ◯ LEFT ◯ **Describe how your child handles stairs:** **Carpet** – YES ◯ NO ◯ **Tile** – YES ◯ NO ◯		
Any current Orthotics or Braces?			
Is your child able to:	Sit unsupported?	◯ YES	◯ NO
	Stand unsupported?	◯ YES	◯ NO
	Move from laying on their back to their stomach without assistance?	◯ YES	◯ NO
	"Sit-up" without assistance from lying on their back?	◯ YES	◯ NO
	Walk without an assistive device or handheld support?	◯ YES	◯ NO
	Catch a ball tossed from 5 feet away?	◯ YES	◯ NO
	Throw a ball 5 feet away without loss of balance?	◯ YES	◯ NO
	Run?	◯ YES	◯ NO
	Jump forwards with feet together?	◯ YES	◯ NO
	Hop on one foot?	◯ YES	◯ NO
	Walk Backwards?	◯ YES	◯ NO
	Skip?	◯ YES	◯ NO
What is your goal for your child's therapy			
Any other initial questions or concerns?			