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?

_____

_____

_____

_____

Physical Therapy
New Patient Forms

Home Information

- ☐ Stairs
- ☐ Stairs Handrail
  - ☐ Left
  - ☐ Right
- ☐ Carpet
- ☐ Tile

Describe how your child handles stairs:

_____

_____

Is your child able to:

- ☐ Sit unsupported
- ☐ Stand unsupported
- ☐ Move from laying on their back to their stomach, unassisted
- ☐ "Sit-up" without assistance from lying on their back
- ☐ Walk without an assistive device or support
- ☐ Catch a ball from 5 feet away
- ☐ Throw a ball from 5 feet away without loss of balance
- ☐ Run
- ☐ Jump
- ☐ Jump forward with feet together
- ☐ Hop on one foot
- ☐ Walk backward
- ☐ Skip

Any concerns with nutrition, swallowing, or speech?

_____

_____

Any concerns with dressing or fine motor skills?

_____

_____

Any current orthotics or braces? _____

What is your goal for your child's therapy?

_____

_____

Any other questions or concerns?

_____

_____