Pediatric Physical Therapy Intake

Paso Robles Physical Therapy

General Information

Today's Date: _____ Child's Date of Birth: _____

Child's Name: _____ Gender: M F

Referring Physician: _____ Phone #: _____

Primary Care Physician (if different from above): _____ Phone #: _____

Parent(s) or Caregiver's Name(s): _____

Address: _____

Home Phone #: _____ Mobile Phone #: _____

Work Phone #: _____ Email Address: _____

Can we leave messages regarding appointments on your home and mobile phone(s)? Yes No

Please describe your concerns about your child's development: _____

_____

Is your child attending school/daycare? Yes No; If Yes, where? _____

Teacher's name? _____ Phone #: _____

Grade level? ____ Classroom type? _____ Resource room? Yes No ESL class? Yes No

Resource room and/or ESL classroom teacher's name? _____ Phone #: _____

Does your child receive any services through school? Yes No; If Yes, what services? _____

Therapist's name? _____ Phone #: _____

Does your child have a current Individualized Education Plan (IEP)? Yes No;

If Yes, when and where is the next IEP meeting? _____

If you checked YES and your child is covered by SC Medicaid or Tricare, please provide a copy of your child's IEP before the evaluation takes place which is required for Medicaid Prior Authorization

Please indicate other diagnoses your child has received:

Diagnosis Approximate Date of Diagnosis

Family Background

Is your child an adopted or foster child? Yes No

If Yes, how old was your child when he/she came into your home? _____ Place of birth:_____

Who lives in your home?

Name	Relationship	Age

With whom does the child spend the most time? _____

Language(s) spoken in the home? _____ Primary language? _____

Is there a family history (parents, siblings, extended family) of any of the following?

hearing loss cleft palate speech problem seizure disorder

prematurity mental illness language delay alcoholism

drug use ADD/ADHD reading or learning difficulties

Prenatal and Birth History

Full Term Premature __ wks C-section Vaginal Birth Birth Weight: _____ Length: _____

How long was your child in the hospital following his/her birth? _____ If longer than average, please describe any complications with the pregnancy or delivery: _____

_____

Was your child intubated? Yes No; If Yes, please describe how long your child was intubated and on a ventilator as well as other respiratory support such as CPAP, nasal canula, etc.: _____

_____

During pregnancy did the mother experience (mark all that apply)?

hemorrhaging	drug use	alcohol use
smoking	diabetes	high blood pressure
elevated lead levels	hospitalization (explain)_____	

Medical History

Mark any of the following that apply to your child:

chronic illness	chronic infections	allergies
lung/bronchial issues	sight problems	hearing problems
hospitalizations	sleeping problems/ difficulty sleeping	heart defect
difficulty eating	diabetes	ear infections
seizures	tuberculosis	meningitis
measles	chicken pox	high fever
physical injuries	mumps	whooping cough

other: _____

Please list any other illnesses (other than typical childhood illnesses), hospitalizations, surgeries, and diagnostic testing your child has had: _____

_____

Please list other physicians and specialists who provide care to your child:

Name/Location Specialty Phone Number

Current Medications:

Name	***Dosage***	***Frequency***	***Reason for Medication***

Any known allergies? Yes No; If Yes, please list: _____

Is your child on a special diet? Yes No; If Yes, please describe: _____

What is your child's current weight? _____ pounds _____ percentile

What is your child's current height? _____ inches _____ percentile

Vision tested? Yes No; If Yes, date of last vision test: _____

Vision tested by: _____ Results of vision test: _____

Hearing tested? Yes No; If Yes, date of last hearing test: _____

Hearing tested by: _____ Results of hearing test: _____

History of recurrent ear infections? Yes No; PE tubes placed? Yes No;

If Yes, which ear? Right Left Both

If yes, date last PE tubes were inserted: _____ Tubes placed by: _____

Does your child use any adaptive equipment (glasses, hearing aids, etc.)? Yes No;

If Yes, list: _____

Developmental History

Please list in years and/or months when the following first occurred:

Held head up _____ Cruise _____ Drink from a cup _____ Skip _____

Rolled _____ Walk _____ Chew meat _____ Scribble _____

Sat alone _____ Smile _____ Fingerfeed _____ Potty trained _____

Stood alone _____ Babble _____ Use a spoon _____ Run _____

Crawl _____ Say first word _____ List first word(s): _____

Pull up _____ Say first phrase _____ List first phrase(s): _____

Was there anything irregular about your baby's movements (e.g., skipped crawling, dragged one leg, etc.):

Yes No; If Yes, please describe: _____

Can your child dress him/herself? Yes No

Does your child fall frequently? Yes No

Does your child play well with others? Yes No

Would you describe your child as "overly active"? Destructive? Yes No

Is your child sensitive to touch? Loud noise? Yes No

Does your child have unusual sleeping patterns? Yes No

Is your child extremely shy? Nervous? Yes No

Does your child throw excessive tantrums? Yes No

Does your child prefer to play with older or younger children? Adults only? Yes No

What is the average amount of time your child can spend on one activity? _____

Please describe your child's favorite activities: _____

_____

Handedness: Left Right Undetermined

Please check the types of play your child engages in most often:

___ throwing and shaking toys ___ games with rules ___ rough and tumble play ___ make believe play

___ banging toys together ___ mouthing toys ___ pushing/pulling toys ___ looking at books

Oral Habits and Feeding

Was your child breast-fed? (Until what age? _____) bottle-fed? combination?

Does your child use a pacifier or suck thumb? Yes No; If Yes, how often: _____

Does your child use a bottle? Yes No; If Yes, how many bottles per day? _____

If applicable, how old was your child when he/she discontinued use of:

Pacifier? _____ Bottle? _____ Thumb sucking? _____

Would you describe your child as a "mouth breather?" Yes No

Do you notice excessive drooling? Yes No; If Yes, explain _____

Do you notice excessive mouthing of toys/objects? Yes No; If Yes, explain _____

Would you describe your child as a "picky eater"? Yes No

Mark any of the following that you have observed:

putting too much food in mouth at one time food falling out of mouth

unable to drink without spilling difficulty chewing meats

coughing or choking on certain foods (list) _____

avoiding certain consistencies (list) _____

Please describe a typical meal: _____

At what age were solids introduced? _____ What kind of cup does your child typically drink from? _____

Therapy Information

Is your child currently enrolled in First Steps (BabyNet)? Yes No; If Yes, which county? _____

Service Coordinator/Early interventionist's Name? _____ Phone #: _____

Please list other therapies your child is receiving:

Type of Therapy Frequency Location Name of therapist Therapist Phone #

When was the last evaluation or re-evaluation that your child received for:

Speech therapy: _____; Occupational therapy _____; Physical therapy _____

Please include any information not included on this form you would like to share: _____

_____

_____

_____

Thank you for taking the time to fill this form out completely. Please sign or type name below and either submit electronically or print and bring to your evaluation.

Signature:_____ Relationship:_____

Date: _____

Paso Robles Physical Therapy

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