Initial Visit Patient Form

Name of Patient:_____ Date:_____

Gender:_____ DOB_____

Name of Legal Guardian_____Relationship_____

Primary Pediatrician_____

Insurance Information_____

Medical History of Minor (If info not available or don't know write N/A)

Birth weight_____ Birth Height_____ NICU stay? Yes No

If Yes, length of stay_____ Did your child pass their hearing test performed at the hospital? Yes or No

Any significant medical history?

_____

Most recent Visit to pediatrician? (MM/DD?YYYY)_____

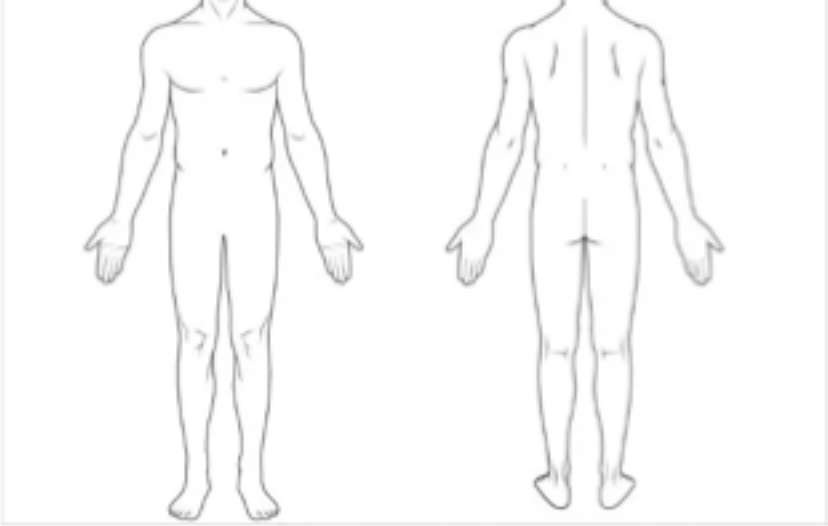
Why were you referred to us?_____

What are your concerns?_____

Circle what areas you are concerned for your child or areas where there is pain?

List any medication your child is taking and dosage._____

_____



_____

Any known allergies?

_____

_____

Has your child received Physical therapy services before? If so, when and why?

_____

_____

Developmental Milestones

At what age did your child start: rolling____

Sitting upright independently____ Crawling_____ Pulling to stand____

Cruising around furniture_____ Walking____

Any remarks you would like the physical therapist to know about your child before the initial

evaluation_____

_____

_____

_____

Person completing this form_____