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Who is completing this form today? _____

Relationship to Person being evaluated? _____

Child's Name (First) _____(MI) _____(Last)_____

DOB: _____Age: _____Gender: _____Male _____Female _____Neutral

Please list all known allergies (food, medications, seasonal, etc.)_____

_____

Who does the child currently live with? _____

Describe this child's present state of health: _____

_____

List any diagnosis (Ex. Cerebral Palsy, Autism, Down's Syndrome, etc.):_____

_____

_____

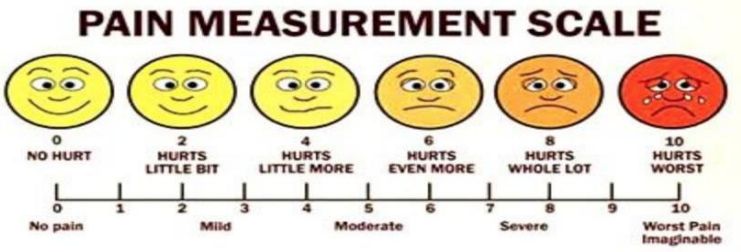
List current medications (Name, Dose, & reason for taking): _____

_____

_____

Has your child experienced any of the following (if yes please explain below):

_____Allergy problems	_____Hearing problems	_____Nightmares
_____Seizures	_____Poisoning	_____Unusual Behaviors
_____Loss of consciousness	_____Operations	_____ Physical/sexual abuse
_____Earaches	_____Vision problems	_____ Going limp or falling
_____Extreme fever	_____Head Injury	_____ Fainting spells
_____Convulsions	_____Swallowing difficulties	_____ Temper tantrums



Have there been any complaints of pain/discomfort in the last 4 weeks? What about today? If so, please rate the pain on the scale.

Onsite Therapies PEDIATRIC + ADOLESCENT

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Please explain: Note any diseases, surgeries, injuries, hospitalizations, or other significant medical history

_____

_____

_____

Has anyone in the child's immediate family (parents, brothers, sisters), EVER been diagnosed with any of the following conditions?

_____Cancer
_____Heart Problems
_____High Blood Pressure
_____Diabetes
_____Stroke
_____Depression
_____Tuberculosis
_____Thyroid Problems
_____Blood Clots
_____Mental Health Issue

Gross Motor Development

At what age did your child sit alone? _____Walk alone? _____

Does your child currently have any adaptive equipment (such as AFO's, wheelchair, booster chair or stander)? If so, which items? _____

List any other gross motor/activity concerns you might have about your child:_____

_____

What activities does your child like to do in their free time? _____

_____

Does your child have difficulty with any of the following tasks?

_____Sitting up without support
_____Crawling on the floor
_____Climbing up & down stairs
_____Rolling a ball back & forth
_____Getting in/out of bed or chair
_____Catching a ball
_____Pushing his/her wheelchair
_____Throwing a ball
_____Moving his/her walker
_____Skipping or running
_____Riding a bicycle
_____Falls a lot
_____Falls when running
_____Doesn't like to jump
_____ Gets tired easily
_____ Dislikes physical exercise
_____ Seems uncoordinated compared to other children
_____ Climbing on/off playground equipment
_____ Walks differently than other children

Gastrointestinal	Urogenital
Swallowing Difficulties? _____	Any recent changes in bowel/bladder function? _____
Regular water drinker? How much water/day? _____	Urine color: _____Flow changes?_____
Any food intolerance? _____	Incontinence? _____
Potty-trained? _____	Regular periods/menstruation? _____
Constipation/Diarrhea? _____	Sexually active? _____
Melena? _____	Any discharge? Color/odor present? _____
Nausea/Vomiting? _____	
Dizzy/Lightheadedness?_____	

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Mental Health	Cardiovascular
During the past month, have you often been bothered by feeling down, depressed or hopeless? During the past month, have you often been bothered by little interest or pleasure in doing things? Is this something with which you would like help?	Current BP: _____HR: _____bpm Quality of pulse_____ Current Height: _____ Current Weight: _____ Please circle one: Over the last 6 months, the current weight has a) increased b) decreased c) stayed the same

PHYSICAL ACTIVITY READINESS QUESTIONNAIRE (PAR-Q)	
Has your doctor ever said that you have a heart condition and that you should only perform physical activity recommended by a doctor?	Do you feel pain in your chest when you perform physical activity?
In the past month, have you had chest pain when you were not performing any physical activity?	Do you lose your balance because of dizziness, or do you ever lose consciousness?
Do you have a bone or joint problem that could be made worse by a change in your physical activity?	Is your doctor currently prescribing any medication for your blood pressure or for a heart condition?
Do you know of any other reason why you should not engage in physical activity?	**If you have answered "Yes" to one or more of the above questions, consult your physician before engaging in physical activity. Tell your physician which questions you answered "Yes" to. After a medical evaluation, seek advice from your physician on what type of activity is suitable for your current condition.**

Thank you so much for completing this information. This will help us be more prepared for our first meeting. Someone from our team will be reaching out to you soon to set up an appointment. If you should have any questions, please feel free to reach out to our office with any questions.

Dr. Angela Johnson, PT, DPT
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