TheraSens, Inc.

Physical Therapy Pediatric Intake Form

Why were you referred to PT? _____

_____

What are your primary concerns? What are you hoping for the therapist to address?

_____

_____

_____

What are your goals for therapy? _____

_____

_____

_____

Does your child ever complain of pain? If so, in what area? Please describe: _____

_____

_____

Medical History

Please list any significant illnesses

- _____
- _____
- _____

Please list any hospitalizations/surgeries

- _____
- _____
- _____

Please list any medical precautions

- _____
- _____
- _____

Please list any allergies

- _____
- _____
-

Please list any medications

- _____
- _____

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Check all the apply:

❑ Chronic ear infection ❑ Tubes placed in ears ❑ Tonsils/adenoid surgery ❑ Reflux ❑ Poor weight gain ❑ Colic ❑ Poor Sleep ❑ Asthma	❑ Lyme Disease ❑ Abnormal muscle tone ❑ Torticollis ❑ Frequent antibiotic use ❑ Frequent fevers ❑ Compromised immune system ❑ Abnormal Lab results ❑ Cardiac issues ❑ Other:_____

Is your child receiving or has previously received any other services? (i.e. Speech Therapy, Physical Therapy, Occupational Therapy, Special Education, Early Intervention, etc.)

What (if any) special equipment does your child use?

❑ Wheelchair ❑ Eye glasses ❑ Hearing aids	❑ Braces ❑ Walker ❑ Crutches	❑ Communication Device: ❑ Other:_____

Developmental History *(complete for patients 5 and under or with a neurological condition)*

Please list any significant prenatal or birth history:

Check all the apply:

❑ Prematurity (Gestation: _____ weeks) ❑ Full Term ❑ Low birth weight (_____ lbs) ❑ Breech birth ❑ C-section birth ❑ Vaginal birth ❑ Forceps use ❑ Vacuum use	❑ Preeclampsia ❑ Gestational diabetes ❑ Breast fed ❑ Bottle fed ❑ Poor suction/latch ❑ Oxygen at birth ❑ NICU stay (duration in NICU:_____) ❑ Other:_____

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Fill in the blanks to describe your child to the best of your ability:

Sat at _____ months/years

Crawled at _____ months/years

Stood at _____ months/years

Walked at _____ months/years

Toilet trained at _____ months/years

Please list any motor development concerns you have (i.e. gross motor, fine motor, oral motor, motor planning, fear of movement, fear of height, etc.)

_____

_____

_____

Check all the apply:

❑ Was placed on his/her belly as an infant ❑ Enjoyed belly time as an infant ❑ Met all milestones on time ❑ Is athletic/play sports ❑ Is good negotiating playground equipment ❑ Is good with his/her hands (fine motor skills)	❑ Was not place on his/her belly as an infant ❑ Did not tolerate being placed on his/her belly as an infant ❑ Was/is developmentally delayed ❑ Is clumsy ❑ Avoids climbing, swinging, sliding ❑ Gets overwhelmed in public places