



kids therapy made simple

Physical Therapy Intake

General Information

child's name: _____

address: _____

parent name: _____

occupation: _____

parent name: _____

occupation: _____

names and ages of those living in the home: _____

referred by: _____

today's date: _____

date of birth: _____

gender: male female

email: _____

phone (h): _____ phone (c): _____

email: _____

phone (h): _____ phone (c): _____

primary language spoken at home: _____

pediatrician: _____

pediatrician phone number: _____

Reason for Today's Evaluation

What are your primary concerns with your child at this time?

When did you first notice these concerns and how did they become apparent to you?

Please describe the reasons for seeking physical therapy services at this time.

Has your child received **previous** evaluations or therapies? yes no

If yes, what kind, where and when?

Is your child **currently** receiving other interventions or therapies? yes no

psychotherapy physical therapy occupational therapy speech therapy vision therapy
 nutritional therapy behavioral therapy other _____

If yes, where and when?

Does your child attend daycare, school or other program? yes no

If yes, where and when?

If no, what is his / her daily schedule? Who is home with him / her?

Birth History

Were there any complications during pregnancy? (e.g. gestational diabetes, preeclampsia, premature labor)

yes no

If yes, please explain.

Did mother take any medication during pregnancy? yes no

If yes, what were they and why were they taken?



What type of delivery did you have? vaginal cesarean

Were there any complications during birth?

- | | | |
|---|---|---|
| <input type="checkbox"/> premature birth | <input type="checkbox"/> breathing difficulty | <input type="checkbox"/> incubation |
| <input type="checkbox"/> jaundice | <input type="checkbox"/> transfusion | <input type="checkbox"/> forceps |
| <input type="checkbox"/> feeding difficulty | <input type="checkbox"/> suction | <input type="checkbox"/> congenital defects |
| <input type="checkbox"/> emergency cesarean | <input type="checkbox"/> tube fed | <input type="checkbox"/> low APGAR |
| <input type="checkbox"/> other complications (please explain) | | |

Where was your child born? hospital birthing center home

If hospital or birthing center, please name the facility:

Term: _____ weeks

Birth weight and length: _____

Mother's age: _____

Father's age: _____

days in hospital _____

Was your child in the NICU? yes no

If yes, why and for how long?

The following are a list of infant behaviors. Please check all that apply to your child as an infant:

- | | | |
|--|--|---|
| <input type="checkbox"/> cried a lot, fussy, irritable | <input type="checkbox"/> resisted being held | <input type="checkbox"/> good, non-demanding |
| <input type="checkbox"/> floppy when held | <input type="checkbox"/> alert | <input type="checkbox"/> tense when held |
| <input type="checkbox"/> quiet or passive | <input type="checkbox"/> very active | <input type="checkbox"/> liked being held |
| <input type="checkbox"/> good sleep patterns | <input type="checkbox"/> drooled excessively | <input type="checkbox"/> irregular sleep patterns |

Developmental History

How old was your child when he/she first:

rolled over: _____

sat independently: _____

crawled: _____

did your child crawl on all fours? yes no

pulled to stand: _____

walked independently: _____

talked (single word): _____

spoke in sentences: _____



Nutritional History

Does your child experience any difficulty with feeding or weight gain? yes no

spitting up

refusal to eat

fussy eater

overeating

other feeding problems

Self-Care

Does your child participate in getting dressed? yes no

Does your child require assistance to:

put on / take off their shirt

pull up / take off pants

put on / take off socks

put on / take off shoes

tie shoes

Is your child toilet trained? yes no

Do they still have accidents? yes no

If yes, what time of day do the accidents typically occur?

Sleep Patterns

Does your child experience any difficulty falling asleep? yes no

What time does your child go to bed for the night? _____

What time does your child wake up in the morning? _____

Does your child sleep through the night? yes no

If no, how many times does he / she wake up during a typical night? _____

Does your child still nap? yes no

If yes, how many naps per day? _____

What time does your child go down for a nap? _____

How long does your child's nap last? _____



Medical History

Does your child have any medical diagnoses? yes no

If yes, please explain:

Has your child had any of the following? Please check all that apply.

- | | | |
|--|--|--|
| <input type="checkbox"/> frequent colds / respiratory illness | <input type="checkbox"/> frequent strep throat / sore throat | <input type="checkbox"/> birth defect / genetic disorder |
| <input type="checkbox"/> lung condition / respiratory disorder | <input type="checkbox"/> frequent ear infections (tubes?) | <input type="checkbox"/> allergies or asthma |
| <input type="checkbox"/> heart condition | <input type="checkbox"/> anemia / blood disorder | <input type="checkbox"/> kidney / renal disorder |
| <input type="checkbox"/> hormonal problem | <input type="checkbox"/> urinary problems / infections | <input type="checkbox"/> muscle disorder / problem |
| <input type="checkbox"/> joint or bone problem | <input type="checkbox"/> fractured bones | <input type="checkbox"/> skin disorder / problem |
| <input type="checkbox"/> visual disorder / problem | <input type="checkbox"/> eye infection | <input type="checkbox"/> neurological disorder |
| <input type="checkbox"/> seizures or convulsions | <input type="checkbox"/> stomach disorders | <input type="checkbox"/> vomiting / digestion problems |
| <input type="checkbox"/> failure to thrive | <input type="checkbox"/> feeding problems | <input type="checkbox"/> constipation |
| <input type="checkbox"/> diarrhea problems | <input type="checkbox"/> hearing loss / ear disorder | <input type="checkbox"/> significant accidents / trauma |
| <input type="checkbox"/> head injuries / concussions | <input type="checkbox"/> injections (botox, etc.) | <input type="checkbox"/> ingestion of toxins, poisons or foreign objects |

Has your child ever had any imaging or special tests performed? yes no

X-ray MRI CT Scan other: _____

If yes, please provide the date and results given.

Has your child had any major medical procedures / surgeries? yes no

If yes, please provide the date and results given.

Has your child taken any medication for longer than 30 days / is your child taking any maintenance medications?
(please list medication, time of day it is taken and what it is treating)



Has your child had any major medical illnesses (e.g. chickenpox, hand, foot and mouth, croup, etc.):

Does your child currently use or has he / she in the past used equipment or other assistive device?
(e.g. orthotics, gait trainer, etc.) yes no

If yes, please list device and when it was used.

Has your child received all of the vaccinations recommended by your pediatrician? yes no

If no, please explain.

Has your child had a hearing test? yes no

If yes, please list date of test and results?

Has your child had an eye exam? yes no

If yes, please list date of test and results?

Does your child wear glasses? yes no

Behavioral History

Does your child experience difficulty following directions at home? yes no

If yes, what is his / her typical response?

Does your child experience difficulty with any of the following:

transitioning away from a preferred activity

dealing with unexpected change in routine

If yes, what is his / her typical response?

transitioning from one activity to another

transitioning from one environment to another



Does your child become frustrated easily?

yes

no

If yes, what does he / she do?

What does your child enjoy doing?

Educational History

Please complete the following **only** if your child attends preschool, kindergarten, elementary school, middle school or high school.

name of current school: _____

school address: _____

school phone: _____

email: _____

teacher's name: _____

Does your child have an Individualized Education Plan (IEP)?

yes

no

If yes, what service(s) does he / she receive?

If your child is in private school, does he / she receive any Special Education Services?

yes

no

If yes, what service(s) does he / she receive?

Has your child's teacher shared any concerns with you regarding your child?

yes

no

If yes, please describe.

Thank You!

