PT N' PLAY PHYSICAL THERAPY INC.
INTAKE FORM

Child's Name: _____
Date of Birth: _____
Referred by: _____
Parents Name(s): _____
Does the child live with both parents: _____
Address: _____
Home Number: _____
Reason for referral/ Parental concerns:

_____

_____

PARENT 1:	**PARENT 2:**
NAME	**NAME**
AGE	**AGE**
OCCUPATION	**OCCUPATION**
BUSINESS #	**BUSINESS #**
CELL #	**CELL #**
E MAIL	**E MAIL**

PEDIATRICIAN
PHONE
ADDRESS
FAX
E MAIL

DO YOU WANT A COPY OF THE REPORT SENT TO YOUR CHILD'S PEDIATRICIAN? _____

IN CASE OF EMERGENCY CONTACT: _____
RELATIONSHIP: _____
HOME PHONE: _____
CELL PHONE: _____

Prenatal and Birth History:

My child was born at _____ weeks gestational age.

Mother's pregnancy: Normal ☐ yes ☐ no

If no please explain:
_____
_____

Delivery: Normal ☐ yes ☐ no
If no please explain:
_____
_____

☐ vaginal ☐ cesarean
Apgars: ____ at 1 minute _____ at 5 minutes _____ at 9 minutes_____

Sleeping: _____pm to _____ am

Daily naps: _____

Please describe any difficulties encountered with your child's sleeping patterns
_____
_____

Developmental Milestones:

Rolled at ____ months.
Sitting at ____ months.
Crawling on all fours at ____ months.
Cruising along furniture at ____ months.
Walking at ____ months.
Babbling at ____ months.
First word at ____ months.
Did your child crawl on all fours? _____
How much time did your child spend on their tummy per day prior to 7 months? _____

Family History:

Siblings: How many? Ages? _____

Please describe any known developmental disability or orthopedic impairments on both sides of the family:

_____

_____

Medical History:

Previous hospitalizations: _____

DOES YOUR CHILD TAKE ANY MEDICATIONS PLEASE LIST:

_____

Does your child have a medical diagnosis and if so at what age was it diagnosed?_____

_____

Has your child ever been seen by a medical specialist (ex. orthopedist, neurologist) If yes, please describe:

_____

_____

Eating:

Breast or bottle fed as infant? Any problems? Please describe

_____

_____

Did your child drool excessively?

_____

Any eating concerns at the moment?

_____

_____

Activities:

Does your child receive any other special services (ex. Speech and occupational therapy) If yes, please list company name, contact information, and frequency of visits

_____

_____

My child is also involved in:

_____

_____

What are your child's strengths and weaknesses?

_____

_____

Please list your child's favorite toys, games, or activities:

_____

_____

My child dislikes or has the most difficulty wit tasks such as:

_____

_____

Provide any additional information that might be helpful for the physical therapy evaluation:

_____

_____

_____ _____

Parent/Guardian Print **Date**

_____ _____

Parent/Guardian Signature **Date**