pt n' play
PEDIATRIC PHYSICAL THERAPY

Patient Intake Form

Child's Name: _____
Date of Birth: _____
Referred by: _____
Address: _____
Home Number: _____
Reason for Referral:_____

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

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

PEDIATRICIAN: _____
PHONE: _____
ADDRESS: _____
FAX: _____
E MAIL: _____

Prenatal and Birth History:

My child was born at _____ weeks gestational age.
Mother's pregnancy: Normal __yes ____no

If no please explain:_____
_____

Position of fetus: breech __yes ___no
occiput posterior __yes ___no

__vaginal __cesarean
Apgars: __ at 1 minute _____ at 5 minutes _____ at 9 minutes

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

<u>Sleep Schedule</u>: _____pm to _____ am

Daily Naps:_____

Does your child put himself/herself to sleep independently? ____ yes ____ no
Please describe any difficulties encountered with your child's sleeping patterns: _____
_____

<u>Developmental Milestones</u>:
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? _____

<u>Family History</u>:

Siblings: How many? Ages? _____
Please describe any known developmental disability or orthopedic impairments on both sides of the family:

_____

_____

<u>Medical History</u>:

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:

_____

_____

<u>Oral Motor Development</u> :

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

_____

_____

Does child have any known tongue or lip ties? Any surgical releases? Please explain: _____

_____

Did your child drool excessively? _____
Any eating concerns at the moment? _____

Pacifier Use:

☐ **Constantly** ☐ **Only for Sleep**

☐ **Thumbsucker** ☐ **Used to soothe when upset**

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:

_____

_____

Please list any other extracurricular activities and/or programs:

_____

_____

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 with tasks such as:

_____

_____

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

_____

_____ _____

Parent Signature **Date**