Pediatric History Form Date_____

EXERCISABILITIES
PHYSICAL THERAPY ▲ MEDICAL FITNESS
Falls Prevention • Aquatic • Neurologic Recovery

Child's name: _____

Mother's Name: _____ Phone: _____
Father's Name: _____ Phone: _____
Guardian if applicable: _____ Phone: _____
Lives with: _____

Emergency Contact other than Parents: _____ Phone:_____

Please add me to your newsletter list so that I can receive information on upcoming programs and education opportunities. ☐Yes ☐No Email: _____

How did you hear about us? ☐ Newspaper ☐ Magazine ☐Another client/friend ☐ Flyer ☐Website ☐Radio ☐TV ☐ medical provider referral ☐Yellow Pages ☐Other:_____

Does your child have a County Case Manager ? ☐Yes ☐No Name: _____

Medical or functional diagnosis? Please Describe:
_____
_____

Complications during pregnancy? ☐Yes ☐No Describe:
_____
_____

Complications during birth? ☐Yes ☐No Describe:
_____
_____

Frequent ear infections? ☐Yes ☐No ☐Other illness? _____
_____

School/Grade: _____ Teacher: _____
What other services does or has your child receive/d and from/where?
_____

Has your child had a recent evaluation by PT/OT/ or Speech? ☐Yes ☐No What:_____
Where: _____ When: _____
If yes, please get us a copy of this evaluation ASAP.

Does child have an IEP? ☐Yes ☐No IEP Category _____
What are your child's strengths: _____
What are your primary concerns re: your child:
_____

_____

Occupational Therapy:

How does your child sleep? _____
Is your child toilet trained? □Yes □No

Can your child:

Don/doff shoes? □Yes □No
Don/doff socks? □Yes □No
Zip/unzip? □Yes □No
Button/unbutton? □Yes □No
Tie/untie shoes? □Yes □No
Don/doff pants? □Yes □No
Don/doff pullover shirt? □Yes □No
Don/doff front closure shirt? □Yes □No
Don/doff jacket? □Yes □No
Brush teeth? □Yes □No
Brush hair? □Yes □No
Any feeding issues? □Yes □No
How would you describe your child's play? _____
Social interactions? _____

Physical Therapy:

- Describe your child's gross motor skills:
  - Walking: _____
  - Crawling: _____
  - Running: _____
  - Ball skills: _____
  - Bicycle: _____
- Is your child involved in any sports/physical activities such as soccer, T-ball, baseball, swimming, horseback riding, creative movement, etc? _____
- What other physical concerns to you have for your child?

  _____
  _____

Speech/Language Therapy:

Does your child communicate using words, signs or neither? _____
At what age did your child say his/her first word?

_____
Approximately how many words does your child use? _____
Does your child combine words into phrases or sentences? □Yes □ No Describe:

_____
Do you or others have difficulty understanding your child's speech? _____
Hearing status: _____
Vision status: _____
Does your child receive Speech services at school? □Yes □No

Please include any recent medical reports; therapy reports or IEPs. The more information you provide the better job we can do to provide your child's services.