Pediatric History Form Date_________________

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:
____
____

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

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.