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PHYSICAL THERAPY PEDIATRIC CASE HISTORY

Evaluation of your child will depend on information about his/her past history. Please complete this form as accurately as possible and avoid leaving blanks. You may feel free to put "unknown" or NA for "not applicable".

Person completing this form:_____Relationship:_____

GENERAL INFORMATION

Child's Name _____Today's Date_____

Nickname_____ Date of Birth_____

Address_____Age_____

City/State/Zip_____Phone #_____

Mother's Name_____ Work/Cell #_____

Father's Name_____Work/Cell #_____

Email Address_____

Siblings (Names, Ages, M/F)_____

Referred by_____

Physician_____Physician's Phone/Fax_____

What language do you use to speak with your child?_____

Are there any other language spoken at home?_____

What language is your child most comfortable speaking?_____

What language does your child understand best?_____

AREAS OF CONCERN

Please describe in detail why you are having your child seen for a physical therapy evaluation? What are your primary concerns?

_____
_____
_____
_____
_____
_____

Is your child aware of the problem? Yes No

If yes, how does she/he feel about it?_____

_____

Have any other physical therapists seen your child? Yes No

Who?_____When?_____

What were their conclusions or suggestions?_____

_____

Have any other specialists seen your child (i.e. physicians, psychologists, special education teachers, speech-language pathologists, occupational therapists)? Yes No

If yes, what type of specialist(s)?_____

When was the child seen?_____

What were the specialist's conclusions or suggestions?_____

_____

_____

PHYSICAL PERFORMANCE

Early Development (give approximate ages and comment on any concerns you may have)

Rolled over Sat alone Crawled_____

Walked alone Toilet Trained First Words_____

Does your child avoid or dislike any functional positions? (Check mark all that apply)

Back Belly Side-lying Sitting Hands & Knees Standing Other_____

Does your child prefer any functional positions? (Check mark all that apply)

Back Belly Side-lying Sitting Hands & Knees Standing Other_____

If your child is walking does she/he fall? (Check mark all that apply)

Never Rarely Occasionally Frequently

If child demonstrates loss of balance does she/he get injured? (Check mark all that apply)

Never Rarely Occasionally Frequently

Does your child demonstrate a foot preference with physical activity? (crawling, walking up and down stairs, climbing, hopping etc.) (Explain or check mark what applies)

Right_____Left_____
No preference noted or Unknown

Please list goals you would like to see your child achieve in therapy:

1._____

2._____

3._____

BIRTH/INFANCY HISTORY

Mother's general health during pregnancy (illnesses, accidents, medications, etc.)

_____

_____

Length of pregnancy: Full Term Premature

Baby's weight at birth:_____

Type of delivery: Head first Breech Planned Cesarean Emergency Cesarean

How long was labor?_____Length of hospital stay_____

Did your child experience any of the following? (Check mark all that apply)

Delayed cry Required oxygen Cord around neck Difficulty breathing

Jaundice Intubation Difficulty swallowing Difficulty sucking

Tube feeding Sleeping problems Colic

Other birth history facts you would like us to know about:_____

MEDICAL HISTORY

Medical Diagnosis (if any)_____

Has your child had a hearing test?_____ Date_____

Results_____
Has your child had a vision test?_____Date_____

Results_____

Please list current medications_____

Does your child have any assistive devices (glasses, orthotics, wheelchair, etc.)

_____

Has your child had any of the following? If so, please explain and list dates, frequency, severity.

Significant Childhood Illnesses_____

Surgeries_____

Serious Injury_____

Allergies_____

Seizures_____

Ear Infections_____

Are there any pertinent family illnesses/medical conditions you would like us to know about?

_____

FEEDING HISTORY

Does your child display any of the following? (Check mark all that apply)

Excessive Drooling Choking/gagging Difficulty Gaining Weight

Regurgitation of liquids/solids Reflux Difficulty Chewing/Swallowing

Do you consider your child to be a picky eater? _____If yes, please explain_____

Does your child have food allergies?_____

EDUCATIONAL HISTORY

Daycare/Playgroups/Preschool_____

Grade_____Frequency_____Type of Classroom_____

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

If so, what special education services is he/she receiving? _____

SOCIAL DEVELOPMENT

What is your child's favorite activity?_____

What is your child's least favorite activity?_____

Does your child play with other children?_____

Does your child demonstrate any repetitive or rigid behaviors?_____

Does your child have excessive tantrums?_____

Is your child involved in extracurricular activities? (i.e. scouts, gymnastics, soccer, swim lessons, etc.)_____

PLEASE LIST ANY ADDITIONAL INFORMATION THAT WOULD BE HELPFUL FOR THIS EVALUATION.

_____

_____

_____

_____

_____

Thank you!

Updated: 3/31/31