Physical therapy at Ability Tree Learning Center

Dear Parent/Guardian,

Please fill out this form prior to coming to your child's initial therapy examination. In order not to delay treatment, please fill out the entire intake form and provide as much detail as you can to better help the physical therapist understand your child and the needs of the family.

It is helpful for parents to fill out this information ahead of time so they can think carefully about the answers. History taking without a health history form can be difficult at the first appointment as children often are very eager to play and have a hard time sitting still while parents answer many questions. Of course, your therapist will still speak with you regarding your child's history. This form is simply designed to speed up the process and insure that your child's therapist has a complete understanding of your child's health. **Furthermore, we strongly encourage you to bring copies of any pertinent medical or school records (i.e. IEP, evals, etc.) to your child's initial examination.**

Thank you for choosing us for your child's therapy needs.

Sincerely,

Nantesha Chen, PT, DPT
Physical therapist

Physical therapy Pediatric intake form

Child's name: ________________________________DOB:____________________ Age:_____________❑M ❑F

Parent(s)/Guardian's name: _______________________Relationship to child:_______________________________

Occupation of Parent/Guardian: ____

Home Address: ____

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Are there stairs to get into the home or in the home? ❑Yes ❑No If yes, how many flights _______________

Who referred you to physical therapy? Full name of referring doctor and their contact information.

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Reason for PT referral: Please include a copy of the PT referral from doctor.

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Current <u>medical</u> or <u>orthopedic</u> diagnosis: Provided by the referring doctor (include any diagnosis provided: ie: ASD, ADHD, speech delay, motor developmental delay, brachial plexus injury, gait abnormality, hip dysplasia, CP, etc.) **How old were they when they received the diagnosis?**

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Please list current medications and what they are for: When do they take it, how many times a day?

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Please list any medical precautions or allergies and reactions:

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Other Doctors and healthcare providers involved in your child's care: (ie neurologist, cardiologist etc)
List reason they are seeing them. How often do they see these doctors and when is next appointment?

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Has your child *previously* received occupational, physical, or speech therapy that *has ended*? How old was your child and what reason *were* they going? What were the results? *When* and *WHY* did the services end? **If your child still receives these services today, then skip to next question.**

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Is your child *currently* receiving any of these therapy services? Check ALL that apply**.**
LIST ***locations***, and **frequency** (how many times a week for each service), **how old** was your child when they started to receive these services?

- □ Speech therapy
- □ Occupational therapy
- □ Physical therapy
- □ Psychological services
- □ Behavioral therapy
- □ ABA
- □ Early intervention
- □ orientation and mobility services
- □ Hearing services
- □ Vision services
- □ Assistive technology services
- □ Other

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What are your primary areas of concern? What are you hoping for the physical therapist to address?
Please check off **all that apply** and explain in detail below and give examples:

Balance	**Upper body strength**	**Safety awareness**
Coordination	**Lower body strength**	**Body awareness**
Endurance	**Overall weakness**	**Equipment Adaptations**
Posture	**Muscle tightness**	**Gait** (how they walk)
Delayed milestones	**Joint laxity (looseness)**	**Other**

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Please list the goals you would like physical therapy to work on? List functional activities (age appropriate activities your child is having difficulty with or you are concerned with**).**

This is what your child has difficulty *doing* (activity) that PT can help with.

This is a small list of examples; please list according to what you desire your child to do in his/her everyday activities, school or playground. *(ie. Walking up the stairs without support, climbing on the monkey bars, running without constantly falling, riding a tricycle or bike, safety awareness to play in the playground safely, running or walking for more than 10 minutes without needing rest, jumping rope with friends/siblings, catching or throwing a ball to play baseball/basketball or other sport, or kicking a ball to play soccer or a specific sport, etc).*

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Does your child ever complain of pain? If so, what area? What makes it better/worse? Please explain**.**

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EQUIPMENT AND ORTHOTIC HISTORY

Please list below any equipment (wheelchair, walker, bath chair, lift, hospital bed, etc.) and any orthotics (AFOs, Back Brace, etc.) that your child has with the approximate date this equipment/orthotic was obtained in addition to the vender/orthotist. Check off any equipment your child currently uses.

☐ Hearing aids ☐ Eye glasses ☐ Communication devices ☐ Other: ______________________

Equipment/ Orthotic	Date Obtained	Vendor/Orthotist

SOCIAL HISTORY

1) Who does your child live with? List name(s) and relationship ___________________________________
   ____
   ____
2) Please list ages of siblings:___________________________________
3) What school/daycare is your child in? What grade (school)? If in Daycare, how many days a week? :____
   ____
4) Does your child have friends? □Yes □No Please explain: ___________________________________
5) Do you feel your child displays appropriate social interactions and/or behaviors for his/her age?
   □Yes □No / If no, explain ___________________________________
   ____
6) Does your child participate in any recreational activities? □Yes □No / If yes, please list: ______________
   ____
   ____
7) Does your child participate in any group classes outside of school/daycare? ❑Yes ❑No
   If yes, please list:___________________________________
   ____

BEHAVIORAL HISTORY

(Please check all that apply to your child) explain below

- ☐ Is social and engaging
- ☐ Makes good eye contact with adults and peers
- ☐ Is well behaved
- ☐ Pays attention
- ☐ Listens well
- ☐ Follows directions well ____1step ____2 step
- ☐ Plays well with other children
- ☐ Is easy going
- ☐ Does well with change
- ☐ Understands safety
- ☐ Takes turns with peers
- ☐ Recalls and tells about everyday events
- ☐ Maintains topic
- ☐ Makes friends easily
- ☐ Is aggressive
- ☐ Is oppositional
- ☐ Does not like new places/people
- ☐ Does not like crowds
- ☐ Has difficulty with transitions
- ☐ Prefers to play alone
- ☐ Has difficulty paying attention
- ☐ Has difficulty listening
- ☐ Is very busy and active
- ☐ Poor coping skills
- ☐ Unable to self calm
- ☐ Extremely sensitive to criticism
- ☐ Quickly escalates without apparent cause
- ☐ Has tantrums

Please list any behavioral or social concerns – or - explain in detail from choices above:

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What are some of your child's favorite toys/interest:

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Please list your child's strengths: List anything that comes to mind (kindness, ball skills, reading):

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DEVELOPMENTAL HISTORY

Is/was your child able to do the following?	**Please Mark**	**If yes, what age did this ability emerge**
Sit independently	❑Yes ❑No ❑N/A	
Crawl or creep independently	❑Yes ❑No ❑N/A	
Walk with support	❑Yes ❑No ❑N/A	
Walk independently	❑Yes ❑No ❑N/A	
Walk with an assistive device	❑Yes ❑No ❑N/A	
Ran	❑Yes ❑No ❑N/A	
Skipped	❑Yes ❑No ❑N/A	
Ride a tricycle	❑Yes ❑No ❑N/A	
Ride a bike	❑Yes ❑No ❑N/A	
Use a Wheelchair	❑Yes ❑No ❑N/A	

MEDICAL HISTORY

Prenatal (before, during or relating to pregnancy) **and Birth History:**
Check all that apply below. List any other significant history not listed below.

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- ☐ Premature (Gestation: _______ Weeks)
- ☐ Full Term
- ☐ Low Birth weight (__________lbs)
- ☐ Breech birth
- ☐ C-Section (planned)
- ☐ Emergency C-section
- ☐ Vaginal birth
- ☐ Forceps Delivery
- ☐ Vaccum Delivery
- ☐ Preclampsia
- ☐ Gestational diabetes
- ☐ Breast fed
- ☐ Poor suction/latch
- ☐ Bottle fed
- ☐ Multiple ultrasounds
- ☐ Oxygen at birth
- ☐ NICU stay (duration in NICU: __________)
- ☐ Other: ______________________________

From birth to present: Check ALL that apply below
Please list any other significant illnesses, hospitalizations, or problems your child experienced from birth to present. - How old were they at that time? **-** What treatments did they receive and what were the outcomes?

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- ◻ Frequent Ear infections
- ◻ Hearing Problems
- ◻ Ear conditions
- ◻ Vision problems
- ◻ Eye Conditions
- ◻ Skin problems
- ◻ Swallowing problems
- ◻ Cognitive problems
- ◻ Emotional problems
- ◻ Behavioral problems
- ◻ High blood pressure
- ◻ Low blood pressure
- ◻ High heart rate
- ◻ Low heart rate
- ◻ Heart/Cardiac conditions
- ◻ Heart murmur
- ◻ Blood disorder
- ◻ Unusual or easy bruising
- ◻ Lung conditions
- ◻ Breathing problems
- ◻ Kidney or bladder conditions
- ◻ Reflux
- ◻ Stomach problems
- ◻ Digestive problems
- ◻ Intestinal problems
- ◻ Diarrhea
- ◻ Constipation
- ◻ Metabolic condition
- ◻ Oral motor problems
- ◻ Sensory problems
- ◻ Sleep problems
- ◻ Dental problems
- ◻ Growth problems
- ◻ Fine motor problems
- ◻ Gross motor problems
- ◻ Broken bone(s)
- ◻ Sprains or strains
- ◻ Head injury, TBI or Concussion
- ◻ Cancer
- ◻ Autoimmune disorder

- ☐ Asthma
- ☐ Lymphatic conditions
- ☐ Seizures
- ☐ Abnormal muscle tone
- ☐ Torticollis
- ☐ Other: ______________________________

Has your child had any surgeries or medical procedures in the past? ❑Yes ❑No Please list, date, and explain.

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Is your child anticipating any upcoming surgeries or medical procedures? ❑Yes ❑No

Please list and explain with anticipated dates.

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Do you have any questions for the physical therapist?

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Comment section: Physical therapist only – please do not write below.