Looking Ahead PEDIATRIC PHYSICAL THERAPY PLLC
Excellence in Infant Head & Neck Disorders

PATIENT IDENTIFICATION

CHILD'S NAME:
DOB: ☐M ☐F
CHILD'S MD: REFERRING MD (if different):
PARENTS' NAMES:
ADDRESS:
HOME PHONE: CELL:
EMAIL:
PREFERRED METHOD OF CONTACT: ☐HOME ☐CELL ☐TEXT ☐EMAIL
LEGAL GUARDIAN'S NAME IF DIFFERENT FROM PARENTS' NAMES:
PERSON COMPLETING THIS FORM:

STATEMENT OF THE PROBLEM

Describe the reason for referral/your concern:
When did you or your referring physician first notice the problem?
What do you feel are some of the reasons for this problem?
Does your child like tummy time? □Y □N How do you practice a day? Total time per session:
Is your child swaddled? □Y □N Describe Where does your child sleep during the day (mark all that apply) ☐Bassinet ☐Crib ☐ Car Seat ☐ Snoo ☐ Bouncey Seat/Swing ☐MammaRoo ☐Parent Bed ☐Parent Arms ☐ Other
Where does your child sleep at night (mark all that apply) ☐Bassinet ☐Crib ☐ Car Seat ☐ Snoo ☐ Bouncey Seat/Swing ☐MammaRoo ☐Parent Bed ☐Parent Arms ☐ Other
Does your child seem as if he/she is in pain? □Y □N Describe:
Is your child currently receiving or has received help for this problem? If so, what type?
Where? When?

PREGNANCY AND BIRTH HISTORY

Were there any complications, illnesses, accidents, or stress producing events during pregnancy? □Y □N
If yes, please explain:
Did the mother use prescription or nonprescription drugs, herbs, or alcohol during pregnancy? □Y □N
If yes, please specify:
Where was the baby born?
At how many weeks? Birth Order (Single, TwinA, etc)?
Birth Weight: Birth Length:
Type of Delivery: □Vaginal □ Planned C-Section □Emergency C-Section Induced: □Y □N
Any complications with labor and delivery? □Y □N Explain:
Did your baby stay in NICU? How Long?
If in NICU, main reason/interventions:_____

Any bruises or abnormalities of your child's head/body? □Y □N Explain:

MEDICAL HISTORY

Date of child's last MD appt:
Date of child's next MD apt:
Immunizations up to date? □Y □N If not please describe:
List any prescription/over-the-counter medications /herbal supplements
Xrays/Ultrasound/MRI? □Y □N When?: Body part:
Allergies: □Y □N Describe:
Has hearing ever been tested? □Y □N When?
Any concerns regarding vision? □Y □N Describe:
Has vision ever been tested? □Y □N When?: Results:
Feeding (check all that apply): □Nursing □Bottle □SippyCup
Did you seek lactation consult: □Y □N If so, who?_____ Describe any feeding issues:

Has your child ever been diagnosed with the following?

Please Check		**By Whom**	**Date**
	Reflux/GERD		
	Tongue/Lip Tie		
	Hip Dysplasia		
	Metatarsus Adductus		
	Cleft Palate		
	Club Foot		
	Gross/Fine Motor Delay		
	Speech Language Delay		
	Neurological Impairment		
	Cognitive Impairment		

Describe any other serious illnesses, hospitalizations, operations, or physical problems not already mentioned_____
_____
_____

DEVELOPMENTAL HISTORY:

At what age did the following occur?

Held head up	Rolled over	Sat alone
Smiled	Responded to Name	Made Eye contact
Babbled:	Pointed:	Crawled:

How would you describe the child's current physical development? □ Normal □ Advanced □ Slow

SOCIAL/BEHAVIOR

Check these <u>if they apply</u> to your child:

□ Floppy when held
□ Tense when being held
□ Resists being held
□ Doesn't make eye contact when held
□ Doesn't respond to name
□ Cries often, fussy, irritable
□ Separation difficulties
□ Doesn't coo or bable
□ Underactive/Overactive
□ Other: _____

Pleas indicate your goals for physical therapy:

_____

_____

_____