PATIENT IDENTIFICATION

CHILD'S NAME:
DOB: ☐M ☐F
CHILD'S PRIMARY/REFERRING PHYSICIAN:
CHLD'S REFERRING PHYSICIAN:
PARENTS' NAMES:
ADDRESS:
HOME PHONE: CELL:
EMAIL:
PREFERRED METHOD OF CONTACT (check all): ☐HOME ☐CELL ☐TEXT ☐EMAIL
LEGAL GUARDIAN'S NAME IF DIFFERENT FROM PARENTS' NAMES:
PERSON COMPLETING THIS FORM:
HOW DID YOU ABOUT US: ☐Physician ☐Friend /Family ☐ Past Patient ☐Insurance Co. ☐ Internet/Website ☐Other:

INSURANCE INFORMATION

INSURANCE NAME:
SUBSCRIBER ID:
GROUP NUMBER:
NAME OF PRIMARY INSURANCE HOLDER :
RELATIONSHIP OF PRIMARY HOLDER TO PATIENT:
DOB OF PRIMARY INSURANCE HOLDER:

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 often do you practice tummy time? For how long each time?	
Where does your child sleep during the day and/or night (mark as D, N, B and mark all that apply) ◻Bassinet ◻Crib ◻ Car Seat ◻Bouncey Seat/Swing ◻Co-Sleeper ◻Parent Bed ◻Rock-n-Play/Momma Roo ◻ Boppy Lounger ◻Other:	
Does your baby sleep during the day and/or night in a swaddle or sleep sack? ◻Y ◻N If YES – please describe	
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?
Who is currently the primary caretaker during the day?	
If attending day care, where?	Full time or Part time?

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?	
Induced or Spontaneous Labor: Vaginal or C-Section Delivery? At how many weeks?	 If C-Section: Planned or Emergency Birth Order (Single, TwinA, etc)?	
Birth Weight:	Birth Length:	APGAR SCORES:
Any atypical problems/complications with labor and delivery? □Y □N		
Please explain:		
NICU stay? □Y □N How many days?	Describe any medical intervention required:	
Were their any bruises or abnormalities of your child’s head/body? □Y □N		

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 with Expressed Milk □Formula Type:
Describe any feeding concerns: Have you been in contact with a lactation consultant?

Has your child ever been diagnosed with the following?

Please Check		By Whom	Date
	Reflux/GERD		
	Club Foot		
	Hip Dysplasia		
	Metatarsus Adductus		
	Cleft Palate		
	Developmental Delay		
	Cognitive Delay		
	Speech Language Delay		
	Neurological 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 Back to Tummy		Sat alone	
Smiled		Rolled over Tummy to Back		Made Eye contact	
Babbled		Responded to Name		Crawled	

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

SOCIAL/BEHAVIOR

Check these if they apply 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: ______________________________

Please indicate your goals for physical therapy: