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

PATIENT IDENTIFICATION

PATIENT NAME:
DOB: ☐M ☐F
CHILD'S PEDIATRICIAN/REFERRING MD:
PARENTS' NAMES:
ADDRESS:
MOBILE PHONE: Additional Phone:
EMAIL:
PREFERRED METHOD OF CONTACT (check all): ☐PHONE ☐TEXT ☐EMAIL
HOW DID YOU ABOUT US: ☐Physician ☐Friend /Family ☐ Past Patient ☐Insurance Co. ☐ Internet/Website ☐Other:

INSURANCE INFORMATION

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

PATIENT DETAILS

Describe the reason for referral/your concern:
Do you feel your baby's head shape appears: ☐ typical ☐ mild ☐moderate ☐ severe ☐N/A
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 many times a day do you practice?
Total amount of time per practice session?
Is your child swaddled for ☐Naps ☐Night ☐Both If so, what Swaddle do you use? ☐Snoo ☐Sleep Sack (open arms) ☐Sleep Sack/Swaddle Arms in ☐Love2Dream ☐Merlin Suit ☐Ollie Swaddle ☐Weighted Swaddle/Sleep Sack
Where does your child sleep during the day (mark all that apply) ☐Bassinet ☐Crib ☐ Car Seat ☐Bouncy Seat/Swing ☐Co-Sleeper ☐Parent Bed ☐Snoo ☐Pack N' Play ☐Lounger
Where does your child sleep at night (mark all that apply) ☐Bassinet ☐Crib ☐ Car Seat ☐ Bouncy Seat/Swing ☐Co-Sleeper ☐Parent Bed ☐Other:
Does your child seem as if he/she is in pain? ☐Y ☐N Describe:

Is your child currently receiving/received help for this concern? 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:
Was mother placed on bed rest? □Y □N Describe
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, Twin A or B, etc)?
Birth Weight: Birth Length:
Type of Delivery: Induced: □Y □N □Vaginal □ Planned C-Section □Emergency C-Section
Any complications with labor and delivery for Mother or Baby? □Y □N Please describe
NICU stay □Y □N How long? Primary reason for NICU stay
Jaundice □Y □N If yes, bili-lights treatment □Y □N How long?
Bruises/abnormalities of your child's head/body? □Y □N Explain:
Breastfeeding difficulties: □Y □N Lactation Consultant □Y □N Name:
Feeding (check all that apply): □Nursing □Pumping □Formula □Sippy Cup
Describe difficulty:

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 /vitamins/herbal supplements
Xrays/Ultrasound/MRI? □Y □N When: Body part:
Describe Why:
Allergies: □Y □N Describe:
Hearing tested at hospital □Y □N Passed □Y □N If No, Follow up Plan
Any concerns regarding vision? □Y □N Describe:
Has vision ever been tested? □Y □N When?: Results:
Feeding (check all that apply): □Nursing □Pumping □Formula □Sippy Cup

Has your child ever been diagnosed with the following?

Please Check	Condition	By Whom	Date	Describe Intervention/Treatment
	Reflux/GERD			
	Tongue/Lip/Cheek Tie			
	Hip Dysplasia/Hip Click			
	Metatarsus Adductus			
	Cleft Palate			
	Club Foot			
	Gross/Fine Motor Delay			
	Speech Language Delay			
	Neurological Impairment			

SOCIAL/BEHAVIOR

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

□ Floppy when held □ Separation difficulties □ Separation difficulties
□ Tense when being held □ Cries often, fussy, irritable □ Overactive/Underactive
Other: _____

Pleas indicate your goals for physical therapy:

_____
_____
_____

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