Child's Name: _____

Early Intervention Associates
Pediatric Physical Therapists

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New Patient Intake Form for Children (2 years +)

Today's Date: _____

Demographics:

Child's Name: _____ Child's DOB: _____

Is your child attending daycare or school? □ Yes □ No

a. If yes, which school/daycare center? _____
b. How many days per week? _____

Background on today's visit:

1. What concerns led you to bring your child for a PT evaluation?

2. What concerns does your child's doctor/teacher/child care provider have, if any?

3. Please describe any previous, or current therapy services received in any disciplines (i.e. physical therapy, occupational therapy, speech therapy, mental health services, vision therapy, etc).

4. How would you describe your goals for your child related to physical therapy?

Child's Name: _____

Medical History:

1. Current Medical Diagnosis, if any: _____

2. Current Medications, if any: _____

3. Birth history: □ Term □ Preterm
□ C-section □ Vaginal delivery

4. Birth weight: _____

5. Medical History: Please check off any current or previous concerns in any of the following areas, and explain below as needed.

□ Birth complications	□ ER visits
□ NICU stay	□ Head injury
□ Vision concerns	□ Hospitalizations
□ Hearing concerns	□ Surgeries
□ Genetic disorder	□ Reflux
□ Seizures	□ Allergies
□ Neurological concerns	□ Behavioral concerns
□ Autism Syndrome	□ Torticollis
□ Delayed language skills	□ Toe walking
□ Chronic ear infections and/or ear tubes	□ Feeding/eating concerns

Please explain:

Developmental History:

If relevant, please indicate the age at which your baby demonstrated the following skills:

Standing alone _____ Walking _____ Jumping _____	Hopping _____

Is there any additional information that you would like us to know about your child?

Child's Name: _____

Toe-Walking history (complete if applicable):

1. At what age did your child begin to toe-walk? _____
2. Does your child experience pain associated with toe-walking? Yes____ No _____
3. On the following line, indicate the percentage of time your child spends walking on his/her toes:

(_____)

0% 10 20 30 40 50 60 70 80 90 100%

4. Check problems or concerns related to your child's toe-walking:

____falling* ____feet turn in (pigeon toe)

____poor balance ____ flat feet, no arches

____tight calf muscles ____ can't stand with feet flat on ground

____teasing by peers ____Abnormal running gait

*How often does your child fall? _____

Are there particular circumstances in which your child is more likely to fall?

_____

Parent Signature: _____ Date: _____