PHYSICAL THERAPY SERVICES

CENTER FOR PEDIATRIC THERAPY
431 Nursery Road, Suite A-100
The Woodlands, TX 77380
PHONE: 281-292-4800/ FAX: 281-292-9588

PATIENT INFORMATION

This form is being completed by: ____

Relationship to child: MOTHER FATHER GRANDPAERNT LEGAL GUARDIAN

LAST NAME:	FIRST:	D.O.B:	SEX:
		/ /	M / F

HOME ADDRESS:	CITY:	STATE:	ZIP CODE:	HOME PHONE:

REFERRING PHYSICIAN INFORMATION

LAST NAME:	FIRST:	ADDRESS:	TELEPHONE:

REASONS FOR TODAY'S VISIT

REASON(S) FOR YOUR CHILD'S VISIT:

Has your child ever received Physical Therapy, Occupational Therapy OR Speech Therapy? Y / N
If yes, when and where?

BIRTH INFORMATION

Were there complications/health problems *during* pregnancy? ☐Yes ☐No
(i.e. Diabetes, toxemia, premature labor)
If YES, please explain:

Labor/Delivery:

Was your child born: ☐Vaginal ☐Cesarean Section

Was the birth an emergency? ☐Yes ☐No

Did the delivery require the use of: ☐Forceps ☐Vacuum ☐Other_________________

Was your child born: ☐Full-term ☐Premature
How many weeks? ___________________
(Gestational Age)

Were there complications during the labor/delivery? ☐Yes ☐No
If YES, please explain:

Immediately After Birth

Did your child:

Spend time in the NICU? ☐Yes ☐No
If YES, for how long? ____

Require use of a ventilator? ☐Yes ☐No
If YES, for how long?____

Jaundice? ☐Yes ☐No
Heart Problems? ☐Yes ☐No
Poor Suck? ☐Yes ☐No
Small for Gestational Age? ☐Yes ☐No
Large for Gestational Age? ☐Yes ☐No

Illnesses at birth:____

MEDICAL HISTORY

Please check all that apply:

☐Measles ☐Mumps ☐Pneumonia ☐Chicken Pox
☐Bronchitis ☐Head Injuries ☐Feeding Tubes ☐Meningitis
☐Hydrocephalus ☐Vision Problems ☐Bronchopulmonary Dysplasia
☐Gastroesophageal Reflux ☐Asthma ☐ Other________________

☐Seizures Frequency_____________ Please Describe________________________

☐Ear Infections Frequency_____________ Last Ear Infection_______________________
Treatment Method_______________________________

Known Diagnoses____

Other Medical Complications____

Please List Any Known Allergies:

Please List Any Hospitalizations:

Dates: from_____________________ to______________________

Reason:

<u>Please list any surgery performed and when they were performed:</u>

<u>Tests Performed:</u>

☐MRI ☐CT Scan ☐Genetic Testing ☐X-Rays ☐Other_________________

<u>Please List Current Medications:</u>

Medication	Dose

Other Physicians or Specialists Your Child Has Seen:

Doctor/Specialist	Reason for Visit	Date

DEVELOPMENTAL HISTORY

Please List the approximate age the child accomplished the following:

Milestone	Age
Lift head while on stomach	
Rolled over	
Sat without needing help	
Creep (pulled self along on stomach)	
Crawled	
Stood alone (without help)	
Walked	
Hand preference ☐Left ☐Right	

Does your child have any bladder or bowel difficulties? ☐Yes ☐No
Please Describe____

Describe your current concerns about your child:

Describe your child's strong likes:____

Describe your child's strong dislikes: ____

What are your child's favorite toys/interests?

What are your goals for your child?