Child (Patient) Name:_____ DOB:_____

Parent/Guardian Name(s): _____
Home Phone: _____ Cell Phone: _____ Other Phone: _____
Child's Chronological Age: _____
Pediatrician/Primary Care Physician: _____
Referred By: _____
Diagnosis: _____
Parent Concerns and/or Goals: _____
_____
_____
_____

PREGNANCY HEALTH HISTORY:
Did mother receive prenatal care? YES/NO _____ If YES, starting when? _____
Procedures/testing performed during pregnancy (i.e. ultrasound, amniocentesis): _____
_____
Medications taken during pregnancy? _____
Describe general health during pregnancy: _____
During pregnancy, did mother: Smoke? _____ Drink alcohol? _____ Use drugs? _____ Exposed to toxins? _____
_____

BIRTH HISTORY:
Length of pregnancy (weeks gestation)? _____
Hospital where child was delivered:_____ City, State of birth: _____
Birth weight: _____ Length: _____
Was child delivered via: Vaginal birth?_____ C-section? _____ Breech? _____
Any complications immediately following birth (i.e. NICU, jaundice, heart murmur, seizures, feeding/swallowing/sucking, respiratory distress, apnea, surgeries, septicemia, etc.)? *If YES, please list:* _____
_____
_____

HEALTH HISTORY(SINCE BIRTH):
Illnesses:_____
Surgeries:_____
Hospitalizations:_____
Diagnostic testing/imaging performed: _____
Current Medications/vitamins/supplements: _____
Allergies:_____
Does your child use any adaptive/medical equipment? *(Please Circle All That Apply)* Eye Glasses, Orthotics, Assistive Device, Protective Helmet, PE Tubes, Trach, Shunt, Oxygen, Feeding Tube, Apnea Monitor, Nebulizer. *If other, please list:*
_____
Does your child currently receive any other therapies/services? *(Please Circle)* OT, Speech, Special Instruction, Aquatic, Hippotherapy. *Other:*_____
Does your child see any medical specialists (i.e. orthopedist, GI, ENT, pulmonologist, etc.)? *If yes, please list the Doctor, specialty, and next scheduled appointment date:* _____
_____

GROSS MOTOR MILESTONES:
At what age was your child able to…

Hold his/her head up while on belly?_____
Roll?_____
Sit independently?_____
Belly crawl?_____
Creep on hands and knees?_____
Stand independently?_____
Walk?_____

Parent/Guardian Signature:

_____

Today's Date: _____