



TheraSens, Inc.

Physical Therapy Pediatric Intake Form

Why were you referred to PT? _____

What are your primary concerns? What are you hoping for the therapist to address?

What are your goals for therapy? _____

Does your child ever complain of pain? If so, in what area? Please describe: _____

Medical History

Please list any significant illnesses

- _____
- _____
- _____

Please list any hospitalizations/surgeries

- _____
- _____
- _____

Please list any medical precautions

- _____
- _____
- _____

Please list any allergies

- _____
- _____
- _____

Please list any medications

- _____
- _____



TheraSens, Inc.

Physical Therapy Pediatric Intake Form

Check all the apply:

<input type="checkbox"/> Chronic ear infection <input type="checkbox"/> Tubes placed in ears <input type="checkbox"/> Tonsils/adenoid surgery <input type="checkbox"/> Reflux <input type="checkbox"/> Poor weight gain <input type="checkbox"/> Colic <input type="checkbox"/> Poor Sleep <input type="checkbox"/> Asthma	<input type="checkbox"/> Lyme Disease <input type="checkbox"/> Abnormal muscle tone <input type="checkbox"/> Torticollis <input type="checkbox"/> Frequent antibiotic use <input type="checkbox"/> Frequent fevers <input type="checkbox"/> Compromised immune system <input type="checkbox"/> Abnormal Lab results <input type="checkbox"/> Cardiac issues <input type="checkbox"/> Other: _____
---	---

Is your child receiving or has previously received any other services? (i.e. Speech Therapy, Physical Therapy, Occupational Therapy, Special Education, Early Intervention, etc.)

What (if any) special equipment does your child use?

<input type="checkbox"/> Wheelchair <input type="checkbox"/> Eye glasses <input type="checkbox"/> Hearing aids	<input type="checkbox"/> Braces <input type="checkbox"/> Walker <input type="checkbox"/> Crutches	<input type="checkbox"/> Communication Device: <input type="checkbox"/> Other: _____
--	---	---

Developmental History *(complete for patients 5 and under or with a neurological condition)*

Please list any significant prenatal or birth history:

Check all the apply:

<input type="checkbox"/> Prematurity (Gestation: _____ weeks) <input type="checkbox"/> Full Term <input type="checkbox"/> Low birth weight (_____ lbs) <input type="checkbox"/> Breech birth <input type="checkbox"/> C-section birth <input type="checkbox"/> Vaginal birth <input type="checkbox"/> Forceps use <input type="checkbox"/> Vacuum use	<input type="checkbox"/> Preeclampsia <input type="checkbox"/> Gestational diabetes <input type="checkbox"/> Breast fed <input type="checkbox"/> Bottle fed <input type="checkbox"/> Poor suction/latch <input type="checkbox"/> Oxygen at birth <input type="checkbox"/> NICU stay (duration in NICU: _____) <input type="checkbox"/> Other: _____
--	--



TheraSens, Inc.

Physical Therapy Pediatric Intake Form

Fill in the blanks to describe your child to the best of your ability:

Sat at _____ months/years

Crawled at _____ months/years

Stood at _____ months/years

Walked at _____ months/years

Toilet trained at _____ months/years

Please list any motor development concerns you have (i.e. gross motor, fine motor, oral motor, motor planning, fear of movement, fear of height, etc.)

Check all the apply:

<input type="checkbox"/> Was placed on his/her belly as an infant	<input type="checkbox"/> Was not place on his/her belly as an infant
<input type="checkbox"/> Enjoyed belly time as an infant	<input type="checkbox"/> Did not tolerate being placed on his/her belly as an infant
<input type="checkbox"/> Met all milestones on time	<input type="checkbox"/> Was/is developmentally delayed
<input type="checkbox"/> Is athletic/play sports	<input type="checkbox"/> Is clumsy
<input type="checkbox"/> Is good negotiating playground equipment	<input type="checkbox"/> Avoids climbing, swinging, sliding
<input type="checkbox"/> Is good with his/her hands (fine motor skills)	<input type="checkbox"/> Gets overwhelmed in public places