Exceptional Horizons Physical Therapy, PLLC

Medical/Developmental History

Name of Child:_____ DOB:_____ Today's Date:_____
Age:_____ Grade:_____
School:_____
Mother's Name:_____
Occupation:_____
Father's Name:_____
Occupation:_____
Address: _____
Contact Information: Please list both parents where applicable
Home:_____
Cell:_____
EMail:_____
Emergency Contact:_____
With whom does child live: (Please check all that apply)
Mother_____ Father_____ Siblings_____(How many:_____ Ages:_____)
Grandparents_____ Foster Care_____(How long has child been in your care? _____)
Has your child ever received PT? YES NO
If so, when and where?_____
Has your child received any other evaluations or treatments? _____
_____
Date of Eval._____
Professional_____
Date of Eval._____
Professional _____
Date of Eval._____
Professional _____
Who referred you for physical therapy treatment?_____
_____
Does your child currently receive any other therapy services? YES NO
If yes, please list where services are provided as well as therapist and frequency:
_____
_____
_____
_____

Medical History

Pediatrician:_____

Phone:_____

Medical Diagnosis:_____

Date of last medical checkup:_____

Has your child received all recommended immunizations? YES NO

If no, please list immunizations withheld:_____

_____

_____

Please list the medications your child is currently taking:_____

_____

_____

Allergies: YES NO

Type:_____

Is your child on a special diet or do they have any food restrictions? YES NO

If yes, please describe:_____

_____

Seizures: YES NO

Type:_____

Medical Precautions:_____

Congenital Abnormalities:_____

Diagnostic Tests (X-ray, MRI, etc) Results:

_____

_____

_____

Critical Injuries:_____

_____

Surgeries:_____

_____

Hospitalizations:_____

_____

_____

Childhood Disease or Major Illnesses:_____

_____

_____

Gastrointestinal Problems:_____

Ear Infections/Frequency:_____

Tubes in ears: YES NO

Hearing Test: YES NO
Results:_____
Does your child wear a hearing aid? YES NO
Vision Test: YES NO
Results:_____
Does your child wear glasses? YES NO

Prenatal Health

Medications:_____
Infections:_____
Illness:_____
Unusual Stress:_____
Exercise:_____
Age of mother at birth:_____

Child's Birth

Please describe labor and delivery:_____

Birth Weight:_____ Premature: YES NO If yes, # of Weeks: _____
C-Section (scheduled or emergency):_____
Forceps used during delivery: YES NO Vacuum used during delivery: YES NO
Anesthesia used: YES NO If yes, list type:_____
Describe any unusual conditions at or immediately after birth (feeding, swallowing, breathing, etc.):_____
Breech: YES NO Birth Injuries:_____

Did your child spend time in the NICU: YES NO If yes, how long?_____
Breastfed: YES NO If yes, length of breastfeeding:_____

Infancy/Toddler Development

Feeding Complications:_____
Sleeping Complications:_____
Colic frequency and duration:_____
Describe toddler development (terrible twos, agreeable, explorative, active, passive,etc.)_____
_____
_____
_____

Developmental Milestones (indicate in months or years)
Rolled over:_____ Sit Unassisted:_____ Crawled on hands and knees:_____
Cruised:_____ Walked:_____ Climbed Stairs:_____
Please describe any concerns with physical skills (uncoordinated, falls, etc.):

First Word:_____ Used two word sentences:_____ Toilet trained:_____
Undressed:_____ Dressed:_____
Does your child have a hand preference? YES NO If so, RIGHT or LEFT

Character
Please describe your child's personality:_____

Strengths:_____

Interests:_____

Activities:_____

Please provide any additional information about your child that you would like to share:_____

Goals
What are your PT goals for your child?
1._____

2._____

3._____