

DATE: ____ / ____ / ____

GENERAL INFORMATION:

PATIENT NAME:		DATE OF BIRTH:	
MOTHER'S NAME:			
MOTHER'S CONTACT INFO: HOME #:		CELL #:	WORK #:
FATHER'S NAME:			
FATHER'S CONTACT INFO: HOME #:		CELL #:	WORK #:
MOTHER'S EMAIL ADDRESS:		FATHER'S EMAIL ADDRESS:	
MAY WE CALL YOU DURING THE DAY? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, WHO SHOULD BE CALLED? <input type="checkbox"/> MOTHER <input type="checkbox"/> FATHER	
WHO WILL BRING THE CHILD TO THERAPY? NAME:			RELATIONSHIP:
OTHER CAREGIVER'S INVOLVED:			
REFERRING PHYSICIAN:		PRIMARY CARE PHYSICIAN:	
RETURN TO DOCTOR DATE:		ONSET DATE OF SYMPTOMS:	

PLEASE ANSWER THE FOLLOWING QUESTIONS COMPLETELY

- Patient Barriers?

<input type="checkbox"/> Visual	<input type="checkbox"/> Cultural	<input type="checkbox"/> Reading Skills	<input type="checkbox"/> Stress
<input type="checkbox"/> Cognitive/Verbal	<input type="checkbox"/> Ethnical	<input type="checkbox"/> Motivation	<input type="checkbox"/> Physical
<input type="checkbox"/> Cognitive/Written	<input type="checkbox"/> Emotional	<input type="checkbox"/> Language	<input type="checkbox"/> Financial
<input type="checkbox"/> Age related	<input type="checkbox"/> Auditory	<input type="checkbox"/> Spiritual	
- Please state your child's best learning method:

<input type="checkbox"/> Demonstration	<input type="checkbox"/> Discussion	<input type="checkbox"/> Pictures	<input type="checkbox"/> Verbal	<input type="checkbox"/> Written
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CURRENT PATIENT INFORMATION:

- Current Weight: _____ • Current Length: _____ • Weight at Birth: _____ • Length at Birth: _____
- Gestational Age: _____ • Was child born prematurely? Yes No If yes: Weeks gestation? _____
- Was child breastfed? Yes No • Length of Time: _____ • Mom's age at time of birth: _____
- Was your child admitted to NICU or did he/she remain in newborn nursery? _____
- Did you child receive therapy services prior to returning home (in NICU, PICU, or nursery)? Yes No
- Any previous therapy service provided in school/outpatient? Yes No
- Utero Position: _____ • Infant position at birth: Vertex/ Breech/ Transverse/ Other: _____
- Attendance at a pre-Natal Class: Yes No • Was infant active? Yes No
- Did the infant seem stuck in one position for the past part of pregnancy? Yes No
- How many weeks was the infant stuck? Vertex / Breech / Transverse _____ weeks
- First Child? Yes No • Single / Multiple Birth: Twin A / Twin B

- List any complications during pregnancy (bed rest / low back pain / leg pain): _____

- List any complications during delivery: _____
- List any medication taken by mother during pregnancy & delivery: _____

- Has child ever been treated for torticollis? Yes No
- Has child ever been treated for any other diagnosis? Yes No If yes, please name: _____

- Diagnostic Test: Xray MRI CT Scan US
- Child's sleep position: Supine (on back) Side Prone (on tummy) Other: _____
- If applicable, does your child snore? Yes No • Does your child have frequent ear infections? Yes No
- Please list the age of child at the following milestones (in months):
 Started Walking: _____ Started Talking: _____ Eating Table Food: _____
 Mouthing of toys/hands: _____ Cereal introduced: _____ Pacifier use: _____
 Dress self: _____ Toilet train: _____
- Did your infant have trouble feeding? Yes No If yes: Breast (left/ right) Bottle Feeding
- Jaundice? Yes No • Reflux? Yes No Medication: _____
- What kind of food/formula does your child eat? _____
- Who lives at home with the patient? Parents Grandparents Siblings Others: _____
- How does you child typically communicate? Choose one: Gestures Single words Short phrases Sentences
- Is your child understood by others or just family members? _____
- Where do you generally seek information on your child's development? _____
- Did you infant have a normal head shape at birth? Yes No If no, describe: _____

- Who noticed the misshapen head? _____ • What age? _____
- Time child spends in car seat carrier per day? _____ • Type used? _____
- Time child spends in swing per day? _____
- Other infant sitting devices used an time spent in them per day? _____

- Time child spends on back daily: _____ • Time spent on belly daily: _____ • Age Belly time initiated: _____
- Does your infant have a head tile preference: Left Right • Rotation preference: Left Right
- Any other children with tight neck muscles and/or misshapen head? Yes No
- Do you notice any facial asymmetry? Yes No If yes, describe: _____
- Congenital Anomalies:

<input type="checkbox"/> Hip dysplasia / <input type="checkbox"/> Hip subluxation: <input type="checkbox"/> Left / <input type="checkbox"/> Right	<input type="checkbox"/> Facial palsy: <input type="checkbox"/> Left / <input type="checkbox"/> Right
<input type="checkbox"/> Fractured clavicle: <input type="checkbox"/> Left / <input type="checkbox"/> Right	<input type="checkbox"/> Brachial plexus injury: <input type="checkbox"/> Left / <input type="checkbox"/> Right
<input type="checkbox"/> Forceps abrasion: <input type="checkbox"/> Left / <input type="checkbox"/> Right	<input type="checkbox"/> Fractured Clavicle: <input type="checkbox"/> Left / <input type="checkbox"/> Right
<input type="checkbox"/> Cephalohematoma: <input type="checkbox"/> Parietal: (<input type="checkbox"/> Left / <input type="checkbox"/> Right) ; (<input type="checkbox"/> Small / <input type="checkbox"/> Medium / <input type="checkbox"/> Large)	
<input type="checkbox"/> Occipital: (<input type="checkbox"/> Left / <input type="checkbox"/> Right) ; (<input type="checkbox"/> Small / <input type="checkbox"/> Medium / <input type="checkbox"/> Large)	

- List activities your child is having difficulty performing? _____

FM/ HANDWRITING

- Which is your child's dominant hand? Right Left Unknown
- Does your child have difficulty with clothing fasteners? Yes No If yes, explain: _____

- Does your child complain of hand pain/fatigue with writing? Yes No If yes, explain: _____

- Can your child write his/her name? Yes No
- Can your child copy simple shapes? (circle, square, triangle)? Yes No