

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