Intake Paperwork for Moving and Grooving Pediatric Physical Therapy

Child's Name: Birth date: Age (corrected, actual):

Parents Names:

Marital status:

With whom does the child live: Bio Parents/ Foster Parents/ Extended Family

Names and ages of siblings:

Emergency contact (name, relationship, phone):

Phone: Email Address:

Address:

Preferred means of Contact: Email/ Text/ Phone

Where and with whom is your child for the majority of the day: Home/ Childcare/Extended Family

Name of Daycare/Preschool (if applicable):

Referred by (name, profession, phone number):

Pediatrician's name:

Reason for referral:

Medical diagnosis:

Which specialties follow your child?

Specialist Reason Frequency

If Applicable:

Has your child received any previous therapy services:

Please list which therapy services, the dates of therapy, and the company and professional's name:

What was the reason therapy services have stopped (circle one)?

Scheduling difficulties/ Cost/ Interaction with Staff/ Met Goals/ Self Discharged

Has your child been referred to or evaluated by AZEIP? Yes/ No Did they Qualify: Yes/ No

Has your child had a vision/hearing test? Yes/No Results:

Wear glasses? Yes/No

Do you have concerns about their hearing?

Has your child had any of the following: If yes, describe and give approximate dates:

Childhood diseases or major illnesses:

Congenital abnormalities:

Surgery:

Serious injury:

Hospitalizations:

Ear infections:

Tubes in ears:

Allergies:

Seizures:

Medication use (prior and current):

Are there any medical precautions we should be aware of when working with your child: Yes/No

Please explain:

Maternal health during pregnancy:

Were there infections/illnesses/difficulties during pregnancy? Yes/ No

Describe

Receive any medication during pregnancy? Yes/ No

Describe

Have any complications/difficulties during delivery/labor? Yes/ No

Describe

Child's Birth:

Gestation:

Birth weight (lb, oz):

Vaginal/ C-Section If C-Section: Scheduled/Emergency

Require: forceps/vacuum (circle one)

Breech (feet first): Yes/No

Any birth injuries? Yes/No

Describe:

Jaundice: Yes/No

Length of Hospital Stay:

Length of NICU Stay:

Infancy and Early Childhood

Breast or Bottle Fed (circle one) Was the child primarily fed on their left or right side? (circle one)

Are there feeding concerns? If yes, describe

Are there sleeping concerns? If yes, describe

Are there concerns with colic or fussiness? If yes, describe

What position is your child in for the majority of the day?

Does your child avoid any positions? If yes, describe

How many minutes at a time do/did they tolerate tummy time?

Where is tummy time performed? Ground/ Bed/ Parent's Chest/ Boppy

Does your child utilize or look towards one side of their body? If yes, describe

Developmental Milestones: Please note the approximate age in months your child did the following:

Roll tummy to back Roll back to tummy Sat independently

Army crawl Hands and knees crawl Other mode of floor mobility

Pull to stand Cruise Stand independently Walk independently