TAYLOR
PHYSICAL THERAPY

Childs Name:_____ DOB:_____ Age:_____ Ⓕ Ⓜ
Current Diagnosis:_____
Home Address:_____ City:_____ Zip:_____
Daycare/School (if applicable):_____
Grade:_____

Parent/Guardian #1 Name: _____ Occupation:_____
Address: _____ City:_____ Zip:_____
Home Address (if different from above):_____
Phone Number: _____ Home/Work/Cell Email:_____
Siblings (Name and Ages):_____

Parent/Guardian #2 Name: _____ Occupation:_____
Address: _____ City:_____ Zip:_____
Home Address (if different from above):_____
Phone Number: _____ Home/Work/Cell Email:_____

Child's Primary Physicain_____ Phone Number:_____
Referring provider:_____ Phone Number:_____

What are the primary areas of concern? What are you hoping your therapist to address?
_____
_____
_____
What are your primary goals for therapy for your child?_____
_____
_____
Date symptoms started:_____ Symptoms first noticed by whom:_____
Brief description reason for attending therapy: _____
_____
_____

Birth History:
Please list any significant prenatal or birth history:_____
_____
Gestational age at birth:_____ Birth weight: _____
Birth Length:_____
Please check what is applicable: _____ Vaginal Birth _____ C-section
_____Breech _____Head Down Assistance at birth: _____Forceps _____Vacuum

Medical History:
Please list any significant illness, hospitalizations or surgery:_____
_____
_____

Please list any medical precautions/allergies/medications:_____
_____
_____

Check all that apply:

___Reflux
___Poor weight gain
___Poor sleep
___Asthma
___Abnormal Muscle Tone
___Spina Bifida
___Torticollis
___Compromised Immune System
___Brain Injury
___Colic
___Cardiac Issues
___Genetic disorder:_____
___Cerebral Palsy
___ASD
___ADHD
___Other psychosocial disorders
___Other:_____

Developmental History

Please fill in the blanks to describe the approximate age your child completed each activity:

Rolled _____
Sat independently _____
Crawled_____
Pulled up to stand_____
Stood independently _____
Walk independently_____
Ran _____
Fed Self _____
Dressed Self _____
Toilet trained _____
Drank from a cup _____
Smiled _____

Does your child have difficulty with any of the following? (circle all that apply)

Loud noises Bright lights Different textures (dislikes clothing, messy hands, etc.)
Difficulty with grooming (washing hair, getting a haircut, trimming finger or toenails, etc)

Please list other treatment you have received for this condition _____
_____

How did you hear about Taylor Physical Therapy?
_____

List the names of the programs and people that have worked or are working with your child outside of Taylor physical Therapy. **If your child has an IEP through his/her school, please bring us a copy for our records.**

Service	Program Name	Teacher/Therapist	Phone #	Dates

Child Care				
School				
OT				
PT				
Speech				
Psychology				
Counseling				
Caseworker				
Dietitian				
Speciality Dr.				
Other				

I hereby authorize any prior or present treating physician, therapist, school, hospital, or other health institution, to release all medical information by any means of communication to Taylor Physical Therapy.

I also hereby authorize treatment to be administered after evaluation according to the therapists discretion. I hereby consent and authorize Taylor Physical Therapy to utilize my or my child's picture for our medical records. I understand that necessary procedures to be provided will be explained along with the risks and benefits.

INFORMED CONSENT

Parent/Gaurdian Signature:_____Date_____

Parent/Guardian Printed Name:_____ Relationship:_____