Outpatient Rehabilitation
Pediatric Physical Therapy Evaluation
Part A: Patient History

***Please complete enclosed Ambulatory Care Summary List in addition to this form.

What brings your child to therapy today?______________________________

What did it start?______________________________

Does your child have pain? ............ □ Yes □ No

Please rate your child’s pain:
(Circle the face that best describes how your child is feeling)

PAST MEDICAL HISTORY:
Surgeries and previous interventions (Please be as complete as possible):

BIRTH HISTORY:
Complications during pregnancy:______________________________

Weeks of gestation at birth:__________ □ Vaginal □ Caesarean

Complications during delivery:______________________________

SOCIAL HISTORY:
Who is your child’s primary caregiver?______________________________

Did/does your child attend daycare? ...... □ Yes □ No If yes, where______________________________

Is your child in school? ................. □ Yes □ No If yes, where______________________________ Grade level __________________

Please describe any other services, in school or at home, your child is currently receiving or has received in the past.

MOTOR MILESTONES:
□ Normal

If atypical or delayed, list your child’s age at the time of demonstration for the following:

Rolling over: ___________ Sitting up: ___________ Crawling: ___________

Cruising: ___________ First words: ___________ Walking: ___________

Eating with spoon/fork: ___________

Other/Comments: ______________________

List your physical therapy goals for your child:______________________________

PARENT / GUARDIAN SIGNATURE ___________________________ DATE ___________

THERAPIST SIGNATURE / LICENSE # ___________________ DATE ___________

REV. 3/19/09