EVERGREEN
PHYSICAL THERAPY SPECIALISTS
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Patient Name:_____ **Date:**_____

Please describe the present complaint(s) which brought you to this clinic for care. _____
_____

Date of Birth: _____

Referring Diagnosis: _____

Referring Physician: _____

Parent/Guardian name: _____

Birth History

1. Delivery (check any complications) : ☐ Diabetes ☐ Excessive Vomiting
   ☐ Weight Loss ☐ Measles ☐ Bleeding ☐ High Blood Pressure
   ☐ Swelling ☐ Toxemia ☐ Other (please specify)_____
2. Length of pregnancy/ Gestational age _____weeks.
3. Delivery: ☐ Vaginal ☐ Cesarean Section
4. Birth Weight _____ Apgar Scores _____/10 **1min** _____/10 **5 min**
5. How long was your child hospitalized following delivery? _____ Discharge date: _____
6. Did your child experience any complications or receive special medical attention? ☐ YES ☐ NO
7. Was your child ☐ Nursed ☐ Bottle Fed?

Medical History

8. Has your child ever been hospitalized or undergone surgery? ☐ YES ☐ NO
9. Does your child have allergies? ☐ YES ☐ NO
10. Please check any of the following that apply to your child:
    - ☐ YES ☐ NO Heart condition
    - ☐ YES ☐ NO Seizure disorder
    - ☐ YES ☐ NO Asthma 493.9
    - ☐ YES ☐ NO Frequent ear infections
    - ☐ YES ☐ NO Diabetes 250.0
    - ☐ YES ☐ NO Hearing impairments
    - ☐ YES ☐ NO Visual impairments
    - ☐ YES ☐ NO Difficulty in swallowing/eating
    - ☐ YES ☐ NO Dermatitis/ Eczema rash
    - ☐ YES ☐ NO Congenital deformities
    - ☐ YES ☐ NO Irregular sleep habits
    - ☐ YES ☐ NO Persistent irritability

☐ YES ☐ NO Withdrawn or isolated behavior

☐ YES ☐ NO Markedly limited attention span

☐ YES ☐ NO Other_____

11. Is your child on prescribed medications? ☐ YES ☐ NO
12. Please list all physicians involved in your child's care and specify for what medical condition:

_____

_____

Developmental History

1. Please note the appropriate ages at which your child accomplished the following milestones:
    a. Rolled from stomach to back _____months
    b. Reached for objects _____months
    c. Rolled from back to stomach _____months
    d. Crawled on stomach _____months
    e. Sat independently _____months
    f. Crawled on hands and knees _____months
    g. Walked independently _____months
2. When did you begin having concerns regarding your child's development?

_____

_____

3. Please list your current concerns regarding your child's development:_____

_____

4. Has your child ever received ☐ Occupational Therapy ☐ Physical Therapy?
   Please explain prior treatment and response: _____

_____

5. Does your child currently receive school based ☐ Occupational Therapy ☐Physical Therapy?
   Please list frequency, name of school, and therapist:_____

_____

6. What would you like to accomplish with therapy? _____

_____

Prenatal History

1. Were you taking any medications during your pregnancy? ☐ YES ☐ NO
   If yes, please list medications and reason: _____
2. Did you use any of the following during pregnancy? ☐ YES ☐ NO Tobacco/Cigarettes
   If yes, how often?_____
3. Check any complications: ☐ Diabetes ☐ Excessive ☐ Vomiting ☐ Weight Loss
   ☐ Measles ☐ Bleeding ☐ High Blood Pressure ☐ Swelling ☐ Toxemia
   ☐ Other (please specify) _____