



Advanced Therapy Care

Therapy Services for Adults and Children

New Patient Physical Therapy Questionnaire

PATIENT INFORMATION			
Patient's Last Name:	First:	Initial:	Birthdate:
Current School:	Grade:	Services at School? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please sign release and bring copy of current IEP	

Why are you having your child evaluated by Physical Therapy?

Brief medical history:

Does your child currently take any medications? If yes, please list

Does your child have a history of the following? If yes, please explain

Developmental Delay / Disability Yes No

Traumatic Brain Injury Yes No

Cardiopulmonary Dysfunction Yes No

Hematologic D/O Yes No

Musculoskeletal D/O Yes No

Neuromuscular D/O Yes No

Burn Injuries Yes No

Infectious Conditions Yes No

Cancer Yes No

Diabetes Yes No

Birth Defects Yes No

Aggression: Yes No

(hitting, biting, kicking, punching, throwing objects)

Other: Yes No

Are you concerned about the way your child uses his/her body to play, do school work, or do every day tasks?

Yes No

Please describe your concerns:

Are there upper body (posture, shoulder, arm, head, and/or fingers) concerns?

When and why did you become concerned about your child's movement abilities?

Do you have concerns related to eye/hand coordination? (reading the board and copying) Yes No

If yes, please describe:

Can your child follow directions? Yes No

Does your child play with peers? Yes No

Does your child play on the playground? Yes No

Does your child play with toys? Yes No

Are you concerned about the way your child perceives the following sensory information?

- Auditory/Hearing
- Mouth/Oral
- Visual
- Touch/Tactile
- Balance

My child walked at: _____

My child crawled at: _____

Is your child over-reactive, reactive/sensitive, or under-reactive to the above? (please describe)

Does your child have difficulty with social or emotional responses? (please describe behaviors)

What are your child's strengths and weaknesses?

Is there anything you'd like to report about your child's functioning?

Do you have any additional concerns not previously reported?

Are you concerned about your child's communication skills? Yes No

Please describe your concerns:
