New Client Intake Form (Pediatrics)

Client Information:

Patient First Name: _____ Patient Last Name: _____ DOB: _____

Parent/Guardian 1: _____ Relationship to Patient: _____

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Address: _____ City/State: _____ Zip Code: _____

Phone: _____ Secondary Phone: _____ Email: _____

Referring Provider: _____ Referring Provider Phone: _____

Do you authorize us to contact your child's physician to share patient health information/medical records? Y____ N____

How did you hear about us? _____

Birth/Medical History:

Pregnancy Gestation (weeks): _____

Did your child require a NICU stay? Yes No

NICU Stay Duration: _____

Pregnancy/Birth Complications: (Check all that apply):

- ☐ Gestational Diabetes
- ☐ Low birth weight
- ☐ Required oxygen/intubation
- ☐ Prematurity
- ☐ Emergent C-section
- ☐ Shoulder dystocia
- ☐ Traumatic delivery
- ☐ Pulmonary issues/disorders
- ☐ Feeding difficulties
- ☐ Multiple pregnancy
- ☐ Cardiac issues/disorders
- ☐ Congenital deformities

Please list any other complications related to pregnancy:

_____

_____

Please list any subsequent hospitalizations, medical events, or illnesses since birth:

_____

_____

_____

Please list any physicians/specialists that care for your child:

_____

_____

_____

Fit Family Physical Therapy, LLC
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Has your child received any of the following medical diagnoses? (Check all that apply):

- ☐ ADHD/ADD
- ☐ Trisomy 21/Down Syndrome
- ☐ Pulmonary disease/dysfunction
- ☐ Genetic syndrome
- ☐ Developmental disorder
- ☐ Epilepsy
- ☐ Autism Spectrum Disorder
- ☐ Congenital heart disease/defect
- ☐ Asthma
- ☐ Cerebral palsy
- ☐ Diabetes
- ☐ GERD/reflux

Known allergies: _____

Medications: _____

Developmental Skill Checklist:

Skill	Met: (Y/N)	Approximate Age:
Lifts head while on tummy		
Holds head up without support		
Rolls tummy to back		
Rolls back to tummy		
Sits independently		
Crawls (belly crawl or hands/knees)		
Stands at furniture		
Stands independently		
Takes steps independently		
Runs up to 10 feet		
Jumps with two feet		
Uses stairs with railing support		

Social History:

Where is your child during the day? (home, school, daycare, etc.) _____

Who cares for your child on a regular basis? (parents, relative, nanny, etc.) _____

_____

Primary Concerns:

What are your primary concerns regarding your child's development?

_____

_____

Have you sought treatment for this concern for your child before? Yes No

List your primary goal(s) for your child's physical therapy treatment:

_____

_____

Is there anything else you would like us to know about your child?

_____

_____

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