Parent Information Form
Physical Therapy

Child's Name ____________________________ Date of Birth__________ Sex: M F

Parent's Names____

Street Address____

City, State, ZIP Code____

Phone Number (Home)_________________________Can we leave a message? Yes No

Cell or Alternate Number____

Mother's Work Phone_____________________ Father's Work Phone________________

Insurance Company____

Other Funding Source____

Pediatrician___________________________________Phone________________________

Address____

Who referred you to the St. John's Mercy Child Development Center?_______________

Reason for referral____

Concerns
In what areas do you have concerns? Please list specific concerns you have observed.

____

____

____

____

____

____

Diagnosis____
Please list any other professionals consulted for your child (i.e., neurologist, psychologist, orthopedist, nutritionist, ENT, GI)________________________________

____

Has your child previously had:

_____Occupational Therapy
Agency/Therapist____

_____Speech and Language Therapy
Agency/Therapist____

_____Physical Therapy
Agency/Therapist____

Medical History
Describe any problems experienced during this pregnancy________________________

____

Hospital where child was born____

Length of labor____________________Type of delivery________________________

Was this a single birth?_____________Birth weight___________________________

Describe baby's condition at birth and/or while in the hospital nursery_______________

____

How long did the baby remain in the hospital?_________________________________

List any serious illness, surgery, or accidents requiring medical treatment___________

____

Date of child's last physical examination________________Results_______________

____

Is your child allergic to any foods or substances? If yes, please list________________

____

List any medications your child is now taking: prescriptions, over-the-counter, vitamins, or herbal supplements.

Medication	Dosage	Doctor Prescribing

Has your child had vision testing? Yes No Date__________ By whom______________

Results____

Does your child war glasses?____

Has your child had hearing testing? Yes No Date_________ By whom______________

Results____

Does your child have a history of ear infections? Yes No

If so, when did they start and how many has your child had?_________________

If so, how were they treated?____

Developmental History At what age did your child do the following?

Roll over___________________________

Hold a toy__________________________

Sit alone___________________________

Crawl______________________________

Stand alone_________________________

Walk______________________________

Said first word_____________________

Used sentences (3-4 words)__________

Fed self using a spoon______________

Removed clothing__________________

Describe your child's usual behavior (i.e., quiet, restless, active, affectionate):_________

____

Does your child have any unusual fears, habits or routines? If yes, please describe.

____

Dos your child like routines and have a need for sameness? If yes, please describe.

____

Play (if yes to any of these questions, please describe)

How does your child spend his/her free time?________________________________

____

Does your child have a favorite toy?____

____

What toys does your child play with?____

____

Communication
How does your child communicate a need or want?____________________________

____

How many words does your child have?______________________________________

How many words in a sentence?____

Does your child respond to his/her name? Yes No

Does your child follow directions? Yes No

Daycare/Preschool/School
Where does your child attend Daycare/Preschool/School?______________________

How many days per week?_______________ A.M. P.M. Full Day

Hours of child's school day:____________________ Grade: ___________________

Extracurricular Activities:
Does your child participate in any extracurricular activities? Yes No

______Swimming
______Basketball
______Soccer
______Gymnastics
______Football
______Choir
______Therapeutic Horsemanship
______Other_____________________________________
______Baseball
______Softball
______Dance
______Martial Arts
______Boy/Girl Scouts
______Hockey

Thank you very much for providing this information. It will be helpful in evaluating your child.