The Everett Clinic

Pediatric Physical Therapy Questionnaire

Please complete the following questionnaire, as this will assist your therapist in the evaluation process. *Thank you!*

Child's Name:_____________________________Date __________________________

Parents Name(s):____

Child's Date of Birth _____________________ ☐R ☐L Hand dominant

Age: _______ Height: ________ Weight: ________ Grade: ____________

History:

Length of Pregnancy (weeks)? __________ Type of Delivery: ___________________

Please describe any complications during your pregnancy or child's birth:
____

For what reason are you bringing your child to therapy at this time:
____

Has your child ever had therapy before (how long/when/type of therapy/where):
____

Who noticed your child had difficulties? Parents Physician When?__________________

List any additional medications or alternative medicines your child is currently taking:
Over the counter &prescription:______________________________

Please list any allergies (including allergy to Latex):
____

GOALS / OBJECTIVES OF PHYSICAL THERAPY

1. I and my child desire to learn : (**Check all that apply**)
   - exercises
   - injury prevention
   - Other:________________________
   - posture correction
   - additional resources that may help me

2. I and my child prefer to learn in the following ways:
   - demonstration
   - verbal instruction
   - video
   - written material

3. My child's / my goals are (ie: activities such as "Play Basketball pain free" "Full neck motion"):

   1. __________________________
   2. __________________________
   3. ___________________________

If you are bringing an **infant** in for physical therapy, fill top page only. If your child is older and/or you have developmental concerns, please continue to fill out the following:

Developmental History:
At what age (in months if applicable) did your child?

Sit alone:_____________
Creep / Crawl: _________
Pull to Stand: _________
Walk alone: ____________

Please list your child's strengths or areas of recent improvement (what makes you smile?)
____

Please indicate which developmental skills are areas of concern for your child. Please provide any comments regarding details of your child's difficulty or your observations of your child's skills in these areas:

Sitting ____________________________
Standing ____________________________
Crawling ____________________________
Walking ____________________________
Sleeping ____________________________
Stair climbing ____________________________
Motor Skills ____________________________
Bathing ____________________________
Eating ____________________________
Dressing ____________________________
Using toilet ____________________________
Writing ____________________________
Vision ____________________________
Other____________________________

Additional History:
1. Check any previous treatments for this problem:

- Physical Therapy
- Social Service
- Support Group
- Dietary Consult
- Speech Therapy
-
- Occupational Therapy
- Splinting
- Surgery (date) __________________
- Chiropractic
- Injection
- Other _________________________

2. Any X-rays, MRI, CT, EMG, etc. taken related to your child's current problem? · yes · no
   If yes, results (include date and where taken):
   ____

3. Past History of **Injuries/Accidents** and Past **Surgical History**:

Year	Description	Year	Description
__________	__________________	_________	__________________
__________	__________________	_________	__________________

Is there any other information you feel might be helpful for the therapist to know before your evaluation? If yes, please explain:
____