SUBJECTIVE

Why are you seeking treatment for your child?
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
Has your child had any prior treatment and/or diagnostic testing for this condition?  □ Yes  □ No
If Yes:  □ X-rays  □ MRI  □ EMG/Nerve Conduction Test
Other: ____________________________________________________________________
If Yes, please explain: ____________________________________________________________________________________________
__________________________________________________________________________
Date of next Doctor’s appointment: ____________________________________________

THERAPIST USE ONLY: I have reviewed the information provided and:       Information is complete       Additional comments below
Subjective History: __________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

CURRENT COMPLAINTS

What are your main concerns regarding your child?
□ Fine Motor (i.e., handwriting, buttoning)  □ Mobility  □ Feeding  □ Behavior  □ Other: ______________
□ Gross Motor (i.e., walking, kicking a ball)  □ Speech  □ Language  □ Other: ______________

THERAPIST USE ONLY: I have reviewed the information provided and:       Information is complete       Additional comments below
Other Related Information: ___________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

PREGNANCY AND BIRTH HISTORY

Were there any complications during pregnancy?  □ Yes  □ No  Comments: __________________________
Was the pregnancy full term?  □ Yes  □ No  Comments: __________________________
Were any drugs or medications taken during pregnancy?  □ Yes  □ No  Comments: __________________________
Was labor and delivery normal?  □ Yes  □ No  Comments: __________________________
Please list birth weight and length: ______________________________________________

THERAPIST USE ONLY: I have reviewed the information provided and:       Information is complete       Additional comments below
Other Related Information: ___________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
INITIAL EVALUATION SUBJECTIVE HISTORY WORKSHEET
Pediatric (page 2)

<table>
<thead>
<tr>
<th>Patient Name: __________________________</th>
<th>Date of Birth: ____________</th>
<th>Date of Eval: ____________</th>
</tr>
</thead>
</table>

GROWTH AND DEVELOPMENT

At what age did your child:

- Roll over from stomach to back? ______
- Roll over from back to stomach? __________
- Sit Independently? ________________
- Crawl? ______________________
- Walk holding onto furniture? _________
- Walk independently? ______________
- Speak first word? ________________
- Speak in 2 word sentences? __________
- Drink from cup? ________________
- Use a spoon? ________________
- Dress independently? ______________
- Toilet train? ________________

Please describe your child:

- Mostly Quiet
- Tires Easily
- Talks Constantly
- Clumsy
- Happy
- Impulsive
- Overly Active
- Overreacts Frequently
- Shy
- Restless
- Craves Touch
- Impulsive
- Gets Frustrated Easily
- Stubborn
- Has Temper Tantrums
- Difficulty Separating
- Has Nervous Habits
- Has Unusual Fears
- Avoids Touch
- Has Poor Attention Span
- Difficulty Learning New Tasks
- Other: ______________________

THERAPIST USE ONLY: I have reviewed the information provided and: [ ] Information is complete [ ] Additional comments below

Other Related Information: __________________________

PREVIOUS MEDICAL HISTORY

How would you classify your child’s general health? [ ] Good [ ] Fair [ ] Poor

Please check ALL that apply:

- Allergies
- Encephalitis
- Multiple Sclerosis
- Rheumatic Fever
- Asthma/Breathing Difficulties
- Enlarged Glands
- Nausea/Vomiting
- Ringing of the Ears
- Bronchitis
- Fever
- Night Pain
- Seizures/Epilepsy
- Cancer
- Head Injury
- Osteoarthritis
- Sinusitis
- Chest Pain/Angina
- Headaches
- Osteoporosis
- Smoking History
- Chicken Pox
- Heart Disease
- Pacemaker
- Stroke/TIA
- Chronic Colds
- High Blood Pressure
- Parkinson’s Disease
- Surgeries
- Chronic Laryngitis
- Hypoglycemia
- Physical Abnormalities
- Thyroid Disease
- Congenital Defects
- Measles
- Pneumonia
- Tonsillitis
- Depression
- Meningitis
- Polio
- Tuberculosis
- Diabetes: Type I or II
- Metal Implants
- Pregnancy (Currently)
- Whooping Cough
- Dizziness/Fainting
- Mumps
- Rheumatoid Arthritis
- Rheumatoid Arthritis

Is there any other information regarding your child’s medical history that we should know about? __________________________

Does your child have any of the following? If Yes, please explain in the space provided:

- Earache/Ear Infection  Describe: __________________________
- Hearing Difficulties  If Yes, Aided? __________________________
- PE Ear Tubes Inserted  Describe: __________________________
- Vision Problems  If Yes, Treatment? __________________________

Have you ever purchased or rented Durable Medical Equipment, Orthotics, Prosthetics, or Supplies?

[ ] Yes  [ ] No  Explain: __________________________

THERAPIST USE ONLY: I have reviewed the information provided and: [ ] Information is complete [ ] Additional comments below

Please List Previous Medical History or Co-Morbidities that May Impact Rate of Recovery: __________________________

________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________
MEDICAL PRECAUTIONS/CONTRAINDICATIONS

Are there any factors that may complicate your child’s ability to participate in therapy?  □ Yes  □ No
If Yes, please explain: ________________________________________________________________

Does your child have food allergies?  □ Yes  □ No
If Yes, please list: ________________________________________________________________

Does your child have any movement restrictions?  □ Yes  □ No
If Yes, please list: ________________________________________________________________

THERAPIST USE ONLY: I have reviewed the information provided and: □ Information is complete □ Additional comments below
Other Related Information: ________________________________________________________________

MEDICATIONS

Please list all of the medications [with specific NAME, DOSAGE, FREQUENCY, and ROUTE (ie: by mouth)] that you are currently taking [including over-the-counter, prescriptions, herbals, and vitamins/mineral(s)]: ________________________________

________________________________________________________

COMMUNICATION HISTORY

Please describe any communication difficulties: __________________________________________________________

________________________________________________________

When was the problem first noticed? __________________________________________________________

Other language(s) besides English spoken in the home: __________________________________________________________

THERAPIST USE ONLY: I have reviewed the information provided and: □ Information is complete □ Additional comments below
Other Related Information: ________________________________________________________________

SOCIAL HISTORY/INTERESTS/LIVING ENVIRONMENT

Father’s Name: ___________________________________________ Age: ____ Occupation: ________________________

Mother’s Name: ___________________________________________ Age: ____ Occupation: ________________________

Is he/she adopted?  □ Yes    □ No    If Yes, at what age? ______

Parent’s Marital Status    □ Married    □ Living Together    □ Separated    □ Divorced    □ Remarried

Who lives in the house with this child? __________________________________________________________

THERAPIST USE ONLY: I have reviewed the information provided and: □ Information is complete □ Additional comments below
Other Related Information: ________________________________________________________________
EDUCATIONAL HISTORY

Does your child attend school?  □ Yes  □ No
If Yes, where?________________________________________ If Yes, what grade(s)?____________________________________
What grade is he/she in? _____________________________

Has your child ever repeated a grade?  □ Yes  □ No
If Yes, where?_______________________________________ If Yes, what grade(s)?____________________________________

Does your child have Special Education or Therapy services in school?  □ Yes  □ No
If Yes, what services?  □ Physical Therapy  □ Occupational Therapy  □ Speech Therapy
How often? ___________________________ How long? ___________________________
Individual/group? __________________________________________________________________________________________
Additional Comments: ______________________________________________________________________________________

Has your child received Therapy anywhere else?  □ Yes  □ No
If Yes, what services?  □ Physical Therapy  □ Occupational Therapy  □ Speech Therapy
Where? _____________________________________________________________________________________________
By whom? ____________________________________________________________________________________________
Additional Comments: ____________________________________________________________________________________

Are there any religious or cultural issues that we should be aware of regarding your child’s evaluation? ____________
_________________________________________________________________________________________________________

PATIENT GOALS FOR THERAPY

What goals are you hoping to have your child accomplish by participating in Therapy? __________________________________
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________

ADDITIONAL RELEVANT INFORMATION

THERAPIST USE ONLY:__________________________________________________________________________________________
________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________

GUARDIAN SIGNATURE

To the best of my knowledge I have fully informed you of the history of my child’s problem and current status.

Patient Guardian’s Signature: _______________________________________________ Date: ______________________
Relationship to Patient: ______________________________________________________________________________________

THERAPIST SIGNATURE

The above information represents all significant subjective findings.

Please refer to the enclosed Objective Findings and Plan of Care for my assessment, treatment goals, and treatment plan.

Therapist’s Signature: __________________________ License # _________________ Date: _______________
Printed Therapist’s Name: ________________________________________________________________________________