First Step
Pediatric Therapy

Patient name: ________________________ Date of Birth: ________________________

Today's date: ________________________

What are your child's current symptoms/diagnosis? Any pain currently?:

____
____
____

When/how did they begin?:

____
____
____

How much does this condition limit your child's normal activity level? Circle one

0 (bed rest) 1 2 3 4 5 6 7 8 9 10 (not at all)

Explain:

____
____
____

Have you had previous treatment or recent testing (imaging, x-ray) for this condition?

____
____
____

History of fractures, significant injuries, or major hospitalizations?:

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____
____

Does your child receive any other outside services (OT, SLP, ABA, etc) or have an IEP?

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____

What are your family's priorities/goals for therapy?:

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____

____

Medical History

Is your child taking any medications?:

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Does your child have any allergies or other precautions?:

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___

Does your child have a significant birth history (prematurity, NICU stay, pregnancy and/or birth complications)?

___

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___

Does your child have a history of any of the following:

_____ Asthma/respiratory concerns	_____ Cancer	_____ Diabetes
_____ Hearing problems	_____ Heart conditions	_____ Hydrocephalus
_____ V/P shunt placement	_____ Reflux/GI issues	_____ Vision problems
_____ ADD/ADHD	_____ Surgery	_____ Stroke
_____ Psychiatric diagnosis	_____ Seizures	_____ Skin conditions

Explain:

___

___

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Seizures

Seizure type	What happens	How long it lasts	How often	Triggers

Seizure first aid:

____
____
____

When to call 911:

____
____
____