Pediatric Therapy Network
Leading the way in helping children

Patient Name _____

New Patient Information

Child's Legal Name: _____
(First) (MI) (Last)

D.O.B. ___/___/___ Age _____ Female/ Male Home# (____) _____

Home Address: _____

City/State/Zip: _____

Parent Email address: _____

Parent/Guardian 1: _____ Cell# /work#:(___) _____

Parent/Guardian 2: _____ Cell# /work#:(___) _____

With whom does the child reside? _____

Emergency Contact Information: Please list who we may call in case of emergency AND who may pick up the child from appointments and receive treatment progress information other than custodial parent or guardian.

Name _____ Ph#_____ Relationship _____

Name _____ Ph#_____ Relationship _____

Name _____ Ph#_____ Relationship _____

Name _____ Ph#_____ Relationship _____

Medical History:

Please list all your child's physicians/ specialties:

Name: _____ Specialty _____

Name: _____ Specialty _____

Name: _____ Specialty _____

Name: _____ Specialty _____

What is your primary concern for having your child evaluated? _____

_____

_____

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Does anyone else have concerns about your child? (Family Member, Physician, Teachers)

_____

_____

Does/Has your child received therapy services (currently or in the past) through any other program/location?

_____

_____

Please list any medical diagnoses that your child has been given:

_____

_____

_____

Please list all your child's medications: _____

_____

_____

Pregnancy /Birth History:

Birth Weight: _____ Weeks gestation: _____

Did child go home with family as expected? _____ Yes _____ No

List any problems or unusual stresses during pregnancy: _____

_____

_____

List any problems after birth (i.e.-jaundice, required oxygen, etc): _____

_____

_____

List any medical problems during first few weeks of life, including hospitalizations: _____

_____

_____

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Developmental Milestones: (please list age at time of reaching milestone **without help)**

Rolling		Finger fed self	
Getting into sitting		Toilet trained	
Sitting alone		Dresses self	
Crawling		Eats with utensils	
First steps		Walk alone	
Spoke first word		Puts several words together	

Health:

Has your child:

Had his/her hearing checked? ____Yes ____ No Date: _____ Results: _____

Had his/her vision checked? ____Yes ____ No Date: _____ Results: _____

Had their immunizations? ___ Yes ___ No Are they up to date? ___ Yes ___ No

Please list any allergies: _____

Are there any diagnosed medical, physical, or emotional problems? Have there been any serious illnesses, injuries or hospitalizations? If yes to any of the above questions, please explain and give dates: _____

_____

_____

Daily Behavior / Communication:

Please describe if your child has any of the following:

Socializing problems: _____

Feeding problem: _____

Sleeping problems: _____

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How does your child: _____

Get along with other children? _____

Let you know his/her needs? _____

Communicate with you? _____

Communicate with others (peers, siblings)? _____

Answer questions or respond to communication? _____

Talk about what he/she is doing? _____

Ask for help? _____

Other:

What are your child's interests?: _____

_____

Please list your goals for therapy (what you would like your child to achieve): _____

_____

_____

Please list anything else you would like us to be aware of: _____

_____

_____

Please let us know how we may contact you regarding appointments and your child's therapy:

___ Home phone/voicemail _____

___ Cell phone/voicemail _____

___ Work phone/voicemail _____

___ Email _____

How did you hear about us?

_____ _____ _____

Parent/Guardian Printed Name | Signature | Date