Colleyville Physical Therapy & Sports Rehab

Southlake Sports & Spine Rehab

Date:_____

PEDIATRIC HEALTH HISTORY

Child's Name: _____ DOB: _____ Primary Care Physician: _____

What are your primary areas of concern/ What are you hoping for the therapist to address:

_____

_____

What are your goals for therapy:

_____

_____

Does your child ever complain of pain? If so, in what are? Please describe:

_____

_____

Please list any medical precautions/ allergies/ medications:

_____

_____

Is your child receiving any other services? (i.e. Speech Therapy, Physical Therapy, Occupational Therapy, Special Education, Early Intervention)

_____

_____

What (if any) special equipment does your child use? (i.e. Orthotics, Wheelchair, Hearing Aids, Walker, Glasses)

_____

_____

Please List any Significant prenatal or birth history:

- ☐ Premature (_____weeks gestation)
- ☐ Full Term
- ☐ Low Birth Weight
- ☐ Breech
- ☐ Vaginal Birth
- ☐ C-Section (Planned)
- ☐ Emergency C-Section)
- ☐ Forceps Delivery
- ☐ Vacuum Delivery
- ☐ Preeclampsia
- ☐ Gestational Diabetes
- ☐ Poor Suction/Latch
- ☐ NICU Stay
- ☐ Other: _____

Please List any significant illness, hospitalization, surgeries:

_____

_____

Developmental History:

Fill in the blanks to describe your child to the best of your ability:

Rolled _____ Sat: _____ Crawled: _____ Walked: _____ Ran: _____

Please list any motor development concerns you have. (i.e. gross motor, fine motor, oral motor, motor planning, fear of movement, fear of heights. etc.)

_____

_____

For Therapist Use Only

Reviewed with patient on: _____ (date) _____ (signature) _____