WAVERLYHEALTH CENTER

Patient Sticker

PEDIATRIC INTAKE FORM

Child's Name: _____ DOB: _____ Age: _____ ☐ F ☐ M
Current Diagnosis: _____
Home Address: _____ City: _____ Zip: _____
Daycare/School (if applicable):_____ Grade: _____

Parent/Guardian #1 Name: _____ Occupation: _____
Address: _____ City: _____ Zip: _____
Home Address (if different from above):_____
Phone Number: _____ Home/Work/Cell Email: _____
Siblings (Name and Ages):_____

Parent/Guardian #2 Name: _____ Occupation: _____
Address: _____ City: _____ Zip: _____
Home Address (if different from above):_____
Phone Number: _____ Home/Work/Cell Email: _____

Child's Primary Physician_____ Phone Number: _____
Referring Provider: _____ Phone Number: _____

What are the primary areas of concern? What are you hoping your therapist to address?
_____
_____
_____

What are your primary goals for therapy for your child?
_____
_____
_____

Date symptoms started: _____ Symptoms first noticed by whom: _____
Brief description reason for attending therapy:
_____
_____

Birth History:
Please list any significant prenatal or birth history:
_____
_____

Gestational age at birth: _____ Birth weight: _____
Birth Length: _____
Please check what is applicable: ☐ Vaginal Birth ☐ C-section
☐ Breech ☐ Head Down ☐ Assistance at birth: ☐ Forceps ☐ Vacuum

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Medical History:

Please list any significant illness, hospitalizations or surgery:

_____

_____

Please list any medical precautions/allergies/medications:

_____

_____

Check all that apply:

- ☐ Reflux
- ☐ Poor weight gain
- ☐ Poor sleep
- ☐ Asthma
- ☐ Abnormal muscle tone
- ☐ Spina Bifida
- ☐ Torticollis
- ☐ Compromised Immune System
- ☐ Brain Injury
- ☐ Colic
- ☐ Cardiac Issues
- ☐ Genetic Disorder: _____
- ☐ Cerebral Palsy
- ☐ ASD
- ☐ ADHD
- ☐ Other psychosocial disorders
- ☐ Other: _____

Developmental History

Please fill in the blanks to describe the approximate age your child completed each activity:

	Approximate Age		Approximate Age
Rolled		Ran	
Sat independently		Fed self	
Crawled		Dressed self	
Pulled up to stand		Toilet trained	
Stood independently		Drank from a cup	
Walked independently		Smiled	

Does your child have difficulty with any of the following?

☐ Loud noises ☐ Bright lights ☐ Different textures (dislikes clothing, messy hands, etc.)
☐ Difficulty with grooming (washing hair, getting a haircut, trimming finger or toenails, etc)

Please list other treatment you have received for this condition _____

_____

How did you hear about Taylor Physical Therapy? _____

Who was your referral source for physical therapy in general: ☐ Physician ☐ Self-Referral

How did you hear about Taylor Physical Therapy specifically? *Check* the appropriate category and check the specific subcategory under each category.

- ☐ Returning Patient:
  - ☐ Newsletter
  - ☐ Postcard
- ☐ Advertising:
  - ☐ Social Media
  - ☐ Radio
  - ☐ Newspaper
  - ☐ Commercial
  - ☐ Flyer
- ☐ Word of Mouth:
  - ☐ Friends & Family
  - ☐ Community event
  - ☐ Friends with Therapist

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List the names of the programs and people that have worked or are working with your child outside of Taylor Physical Therapy. **If your child has an IEP through his/her school, please bring us a copy for our records.**

Service	Program Name	Teacher/Therapist	Phone #	Dates
Child Care				
School				
OT				
PT				
Speech				
Psychology				
Counseling				
Caseworker				
Dietitian				
Speciality Dr.				
Other				

I hereby authorize any prior or present treating physician, therapist, school, hospital, or other health institution to release all medical information by any means of communication to Taylor Physical Therapy.

I also hereby authorize treatment to be administered after evaluation according to the therapist's discretion. I hereby consent and authorize Taylor Physical Therapy to utilize my or my child's picture for our medical records. I understand that necessary procedures to be provided will be explained along with the risks and benefits.

INFORMED CONSENT

Parent/Guardian Signature: _____Date: _____

Parent/Guardian Printed Name: _____ Relationship: _____