Simple To Be…
Physical Therapy
Individualized Needs Assessment/Intake Form

Thank you for choosing *Simple To Be* for your child's PT needs.

Child's Full Name: _____Child's Date of Birth: _____

Name of person completing this form: _____ # of Siblings/ages_____

Relationship to child: _____

Home phone: _____ Cell Phone: _____ email: _____

Referral Information:

Who referred for therapy? :_____

What is your main concern regarding your child? : _____

When these concerns were first noticed? : _____

What do you see as your child's strengths? :_____

What are your goals for therapy? :_____

Pediatrician/Primary Care Physician: Name: _____

: Phone Number: _____

Birth History/Neonatal Period:

Child was born: Full term: no_____ yes_____ Number of weeks premature: _____

Child's delivery was: Vaginal _____ Cesarean _____ Forceps _____ Suction_____ length of labor_____

Describe any problems during pregnancy, labor, or delivery: _____

Did mother have prenatal care? _____

Birth Weight: _____Birth Length_____

Was your child in the NICU? _____NO_____YES If YES how long? _____

Medical Problems at birth:_____

_____

List any specialist your child has seen and why (other than pediatrician or family doctor)_____

_____

Sleep/Nap Schedule (number of naps/day and length of nap): _____

Night-time sleeping: (length and reason for not sleeping through night)—for infants, at what age did infant sleep through the night?

_____

Medical History:

Other health care professionals involved in care:

_____

Family History:

Has your child had any of the following? ***Family history, please circle.***

___ADD/ADHD ___Congenital Heart Disease ___AIDS/HIV ___Chronic Colds

___Asthma ___Autism ___Bronchitis ___Head Injury

___Colic ___Ear Infection ___Headaches ___Skin Rash

___High Fever ___Seizures ___Other_____

Are immunizations up to date currently? _____yes_____no. Please provide reason: _____

_____

Surgeries; type and date: _____

Does your child wear glasses? _____

Medications your child currently taking:

_____

List any allergies to food or medications: _____

Are there any medical precautions of which she should be aware of when with your child?_____

_____

Physical Development:

Please indicate at what age your child achieved the following developmental milestones:

Rolled Over_____ Toilet Trained: _____

Sat up independently: _____ Self Fed Finger Foods: _____

Crawled on hands and knees: _____ Spoon-fed self: _____

Pulled to stand: _____ Slept through the night: _____

Walked: _____ Talked with simple words: _____

Used a cup: _____ Use crayon to color: _____

Ate solid foods: _____ Put two words together: _____

Jumping: _____ Running: _____

If school age, what school is the child enrolled in: _____

IEP: _____YES _____NO

Additional comments:

_____

_____

_____

_____

_____

Additional Information:

Please list a few of your child's favorite toys and games:

_____

_____

List any information that might be helpful in understanding your child:

_____

_____

Signature of person completing this form: _____ Date:_____