Physical Therapy Case History

Patient and Family Information

Child's Name: _____ Birth date: _____ ☐M☐ F
Mother's Name: _____ Daytime Phone: _____
Father's Name: _____ Cell Phone: _____

Primary language spoken in the home: ☐English ☐Spanish ☐Other _____
What are your concerns/what have others told you about your child's fine motor, gross motor, and sensory processing skills?

_____

Birth History

Mother's health during pregnancy: ☐Good ☐Fair ☐Poor Describe

_____

History of alcohol and/or drug abuse during pregnancy: ☐Yes ☐No Describe

_____

Length of Pregnancy _____Child's Birth Weight_____
Problems during or after delivery:

_____

Did the child go home with his/her mother from the hospital? ☐Yes ☐No
If no, please describe why and how long:

_____

Medical History

Please list any current or previous diagnoses:

_____

Medications your child takes regularly:

_____

Has your child taken the prescribed dosage today? ☐Yes ☐No

Allergies to food or medication:

_____

Has your child ever been hospitalized, had a serious accident, broken bones, or had an operation:

_____

Additional medical information:

_____

_____

Developmental History
Please list the approximate age your child achieved the following milestones:
_____ Roll over _____ Crawl
_____ Sit independently _____ Pull to stand
_____ Walk alone _____Learn to Climb
_____Pedal a tricycle

Does your child have problems with:
Balance _____ Coordination_____

Do you have any current concerns about your child's gross motor skills? _____
If yes, please explain:
_____
_____

Do you have any current concerns about your child's ability to navigate stairs? _____
If yes, please explain:
_____
_____

Has your child ever worn braces, orthotics, or shoe inserts? _____
If yes, please describe:
_____
_____

School History
Is your child in a school/daycare? ☐ Yes ☐ No Name of school/daycare:
_____
Grade: _____ Does your child have an IEP? ☐ Yes ☐ No
What (if any) services are your child receiving through school?
_____

Physical Therapy History
Has he/she received early intervention (TEIS/BCW) services in the past/been tested? ☐ Yes ☐ No
Has he/she ever had a speech evaluation/screening? ☐ Yes ☐ No
If yes, where and when?
_____
What were you told?
_____
Has your child ever had physical therapy? ☐ Yes ☐ No If yes, where and when?_____
What was he/she working on?
_____
Has your child received/currently receiving any other therapy? ☐ physical therapy
☐ occupational therapy ☐ counseling ☐ vision ☐ other _____

Is your child aware of, or frustrated by, any current difficulties, fine motor, gross motor, or sensory? ☐Yes☐ No

If yes, please explain:

_____

_____

Self Care

At what age was your child:

Able to dress alone _____	Able to bathe alone _____	Bladder trained_____
Bowel Trained _____	Dry at night_____	Tying Shoelaces _____

Described other problems or unusual habits/preferences with activities of daily living:

_____

Body Systems:

Hearing:

Hypersensitive to some sound_____
Ignores some sounds _____
Inconsistent response to sound_____
No problems_____
Explain as necessary:

_____

Vision:

Difficulty with tracking or depth perception_____
Over-focusing _____
Atypical or odd visual behavior_____
No problems_____
Explain as necessary:

_____

_____

Vestibular/Proprioceptive:

Avoids some movement/posture_____
Seeks out some movement/posture_____
No Problems_____
Explain as necessary:

_____

_____

Pain Threshold:

Higher than expected_____
Lower than expected_____
Inconsistent _____

No Problems_____
Seeks out comfort for injury/pain: Yes_____No _____
Explain as necessary:
_____
_____

Social History:
Your child's favorite toys:
_____
Play skills:☐Prefers to play alone ☐Plays well with other children his/her age☐Excessive shyness/clinging to caregiver ☐Limited initiation of social contact☐ Social anxiety ☐Difficulty maintaining social interaction☐Peer conflict ☐Difficulty showing emotion

Please describe your child's social skills:
_____
_____

Additional comments/concerns regarding your child:
_____
_____