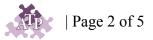


PHYSICAL THERAPY CASE HISTORY FORM

IDENTIFYING AND FAMILY INFORMATION

Patient Name:	Date of P	Birth:		Se	ex: 🗆 Male	□ Female
Mother's Name: Email:						
Cell:	Home: _			_		
Father's Name:	Address:					
Email:						
Cell:	Home:			-		
Patient lives with:						
Birth ParentsAdoptive Parents	☐ Foster Parents □ One Parent				n / Adult pat	
Other Children in Family:						
Name	Age	Sex	Grade		agnosis/Issu	
Is there a language other than Eng	dish spoken in the home	'5 	l r	☐ Yes	🗆 No	
If yes, which one? Does the child speak the la Does the child understand	inguage?		C	☐ Yes ☐ Yes	□ No □ No	
	<u>School</u>	Histor	<u>Y</u>			
Is the patient in school? If yes, plea	ase answer the following	; .				
Name of daycare/school p What are your child's stren Is your child having difficu	gths and/or best subjec	ts?				



STATEMENT OF THE PROBLEM

Describe in your own words what the primary problem the patient is having:

When did you first notice the problem?		
Does the patient have a medical diagnosis/diagnoses?	□ Yes	□ No
If yes, what is it?		
When was it made?		
Who made the diagnosis?		
Has the patient received any other evaluation or therapy (e.g. physical therapy, counseling, occupational therapy, vision)?	□ Yes □ N	0
If yes, please describe:		
What is the patient's most difficult problem in the home?		
What is the patient's most difficult problem in school?		
What are the patient's goals to be addressed through PT services?		
Birth Histor	Y	
Was there anything unusual about the pregnancy or birth? If yes, please describe: How many weeks was the pregnancy? How old was the mother when the child was born?		□ No
Was the mother sick or had any complications during the pregnand If yes, please describe:	cy? 🗆 Yes	□ No
Did the patient go home with his/her mother from the hospital af	ter birth?	□ No
If no, please describe why and how long he/she stayed:		
MEDICAL HISTO	RY	
Has the patient ever had any of the following?		
 Allergies Breathing difficulties Cardiac problems Ear tubes Har infections How Often? 	□ Seizures □ Sinusitis lems □ Sleeping D □ Sleeping D □ Vision Pro	oifficulties



□ Other Problems not listed:			
PCP Name:	Phone:	Fax:	
Other serious injury/surgery:			
Does the patient have any medical diagn		□ Yes	□ No
It yes, please specify:			
Is the patient currently (or recently) und	er a physician's care?	\Box Yes	□ No
If yes, why?			
Please list medical specialist's currently t	reating the patient:		
	nd results (i.e. x-rays, scans, etc.):		
Please list any medications the patient ta			
Does the patient use any assistive device chair/communication device or other): I			:d?
Is the patient experiencing pain? Yes/1	No		
If yes, please indicate location of pain an	ad any activities that make it better	r /worse.	

DEVELOPMENTAL HISTORY

For pediatric patients: Please tell the approximate age the patient achieved the following developmental milestones. Please comment if any were skipped or not yet achieved. Some may not be applicable to the patient yet.

hold head up roll over both directions	reached for object crawl on hands/knees
foil over both directions stood	cruise around furniture
sat alone	walk
spoke first word	grasp crayon/pencil
feed self	bladder/bowel control
drink from open cup	dress independently
ride tricycle	ride bike (no training wheels)



alone

POSTURAL CONTROL

Does/is the patient:

1.	Have a preference to position his/her neck	\Box Yes	\Box No	
2.	Prefer to W-sit or heel sit while playing on the floor?	Yes	🗆 No	
3.	Strong preference to tip toe walk?	\Box Yes	\Box No	
4.	Trips and falls often?	\Box Yes	\Box No	
5.	Slump or hold their head in their hand when sitting at a desk/table?	\Box Yes	\Box No	
6.	Tire easily with motor tasks/poor endurance?	\Box Yes	\Box No	
7.	Prefer more sedentary activities rather than playing outside?	\Box Yes	\Box No	

GROSS MOTOR SKILLS/MOTOR PLANNING

Does/is the patient:

1.	Have slow and deliberate movements with motor activities?	\Box Yes	\Box No
2.	Move too fast and lose control?	\Box Yes	🗆 No
3.	Appear clumsy or awkward?	\Box Yes	🗆 No
4.	Have trouble getting him/her dressed?	\Box Yes	\Box No
5.	Enjoy P.E. and sports?	\Box Yes	\Box No
6.	Have difficulty jumping or running?	\Box Yes	🗆 No
7.	Have difficulty learning new motor skills?	\Box Yes	🗆 No
8.	Able to jump on one foot?	\Box Yes	🗆 No
9.	Have difficulty kicking a ball?	\Box Yes	🗆 No
10.	Have difficulty catching and throwing a ball?	\Box Yes	🗆 No

BEHAVIOR HISTORY

Behavioral Characteristics:

□ Restless	Easy-going
Poor eye contact	□ Sleeps well
\Box Good eye contact	Prefers to play alo
□ Destructive/aggressive	\Box Poor sleeper
□ Withdrawn	\Box Cries easily
□ Inappropriate behavior	□ Happy
\Box Self – abusive behavior	□ Flexible
□ Inattentive	□ High activity level
\Box Acts out	□ Shy
	 Poor eye contact Good eye contact Destructive/aggressive Withdrawn Inappropriate behavior Self –abusive behavior Inattentive

□ Easily distracted/short attention

ADDITIONAL COMMENTS

