Adults To Pediatrics Therapy, LLC

Rehabilitation Services

Physical Therapy Case History Form

Identifying and Family Information

Patient Name: _____ Date of Birth: _____ Sex: ☐ Male ☐ Female

Mother's Name: _____ Address: _____

Email: _____ _____

Cell: _____ Home: _____

Father's Name: _____ Address: _____

Email: _____ _____

Cell: _____ Home: _____

Patient lives with:

☐ Birth Parents ☐ Foster Parents ☐ On own / Adult patient
☐ Adoptive Parents ☐ One Parent ☐ Other _____

Other Children in Family:

Name	Age	Sex	Grade	Diagnosis/Issues?

Is there a language other than English spoken in the home? ☐ Yes ☐ No

If yes, which one? _____
Does the child speak the language? ☐ Yes ☐ No
Does the child understand the language? ☐ Yes ☐ No

School History

Is the patient in school? If yes, please answer the following:

Name of daycare/school program: _____ Grade: _____
What are your child's strengths and/or best subjects? _____
Is your child having difficulty with any subjects? _____

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 ☐ No

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 History

Was there anything unusual about the pregnancy or birth? ☐ Yes ☐ No

If yes, please describe: _____

How many weeks was the pregnancy? _____

How old was the mother when the child was born? _____

Was the mother sick or had any complications during the pregnancy? ☐ Yes ☐ No

If yes, please describe: _____

Did the patient go home with his/her mother from the hospital after birth? ☐ Yes ☐ No

If no, please describe why and how long he/she stayed: _____

Medical History

Has the patient ever had any of the following?

☐ Allergies
☐ Breathing difficulties
☐ Cardiac problems
☐ Ear tubes
☐ Ear infections
☐ Encephalitis
☐ Head Injury
☐ Hearing Problems
☐ High Fevers
☐ Meningitis
☐ Seizures
☐ Sinusitis
☐ Sleeping Difficulties
☐ Sleeping Difficulties
☐ Vision Problems

How Often?_____

☐ Other Problems not listed: _____

PCP Name: _____ Phone: _____ Fax: _____

Other serious injury/surgery: _____

Does the patient have any medical diagnosis? ☐ Yes ☐ No

If yes, please specify: _____

Is the patient currently (or recently) under a physician's care? ☐ Yes ☐ No

If yes, why? _____

Please list medical specialist's currently treating the patient:

_____

_____

Please list any special tests performed and results (i.e. x-rays, scans, etc.):

_____

_____

Please list any medications the patient takes regularly:

_____

Does the patient use any assistive devices or adaptive equipment: (orthotics/splints/walker/bath chair/communication device or other): If yes, please list device/equipment and when was it issued?

_____

_____

Is the patient experiencing pain? Yes/ No

If yes, please indicate location of pain and any activities that make it better /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
_____ stood
_____ sat alone
_____ spoke first word
_____ feed self
_____ drink from open cup
_____ ride tricycle

_____ reached for object
_____ crawl on hands/knees
_____ cruise around furniture
_____ walk
_____ grasp crayon/pencil
_____ bladder/bowel control
_____ dress independently
_____ ride bike (no training wheels)

Postural Control

Does/is the patient:

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

Gross Motor Skills/Motor Planning

Does/is the patient:

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

Behavior History

Behavioral Characteristics:

☐ Cooperative	☐ Restless	☐ Easy-going
☐ Attentive	☐ Poor eye contact	☐ Sleeps well
☐ Willing to try new activities	☐ Good eye contact	☐ Prefers to play alone
☐ Plays alone for reasonable length of time	☐ Destructive/aggressive	☐ Poor sleeper
☐ Separation difficulties	☐ Withdrawn	☐ Cries easily
☐ Easily frustrated/impulsive	☐ Inappropriate behavior	☐ Happy
☐ Stubborn	☐ Self –abusive behavior	☐ Flexible
☐ Friendly/Social	☐ Inattentive	☐ High activity level
☐ Easily distracted/short attention	☐ Acts out	☐ Shy

Additional Comments