Thera-Pēds
Pediatric Therapy

Patient Name:	Today's Date:
Parent Social Security #:	Date of Birth:
Person Completing this Form:	Relationship to Patient:

How long has this condition been present?

☐ Present since birth ☐ Longer than past 12 months ☐ Within past 12 months

What are your primary concerns?

☐ Speech Intelligibility:	☐ 0%	☐ 25%	☐ 50%	☐ 75%
☐ Social Skills:	☐ Play Skills	☐ Eye Contact	☐ Making Friends	☐ Turn-Taking
☐ Speech Rate and Smoothness:	☐ Too Fast	☐ Too Slow	☐ Repeating Sounds	☐ Holding Out Sounds
☐ Language Understanding:	☐ Vocabulary	☐ Sequencing	☐ Answering Questions	☐ Following Directions
☐ Language Production:	☐ Vocabulary	☐ Story Retell	☐ Word Structure	☐ Sentence Structure
☐ Activities of Daily Living:	☐ Bathing	☐ Dressing	☐ Toileting	☐ Feeding
☐ Sensory Processing:	☐ Plays Rough	☐ Touch Sensitivity	☐ Hearing Sensitivity	☐ Light Sensitivity
☐ Motor Abilities:	☐ Strength	☐ Balance	☐ Coordination	☐ Handwriting
☐ Behavior:	☐ Insecure	☐ Distractible	☐ Aggressive	☐ Difficult to Comfort
☐ Other:				

Please indicate any specific concerns/goals you would like addressed in therapy?

Social History

Who lives with patient at home?

☐ Mother ☐ Father ☐ Brother(s): _____ ☐ Sisters(s): _____ ☐ Grandparents
☐ Other:

☐ Durable Medical Equipment:

Birth History

Pregnancy ☐ Received Prenatal Care Pregnancy Length: _____

Please indicate any complications:

☐ Eclampsia	☐ Positive for Herpes	☐ Multiple Births	☐ Positive for Cytomegalovirus (CMV)
☐ Pre-Eclampsia	☐ Positive for HIV	☐ Premature Labor	☐ Substance Exposure
☐ Toxemia	☐ Positive for Strep B	☐ Gestational Diabetes	☐ Other:

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Delivery	☐Vaginal Delivery	☐C-Section Delivery

Please indicate any complications:

☐ Abruptio Placentae	☐ Intrauterine Growth Retardation	☐ Prolapsed Cord
☐ Anemia of Prematurity	☐ IVH Bleed (Grade I-IV)	☐ Respiratory Distress Syndrome
☐ Aspiration Pneumonia	☐ Meconium Aspiration	☐ Respiratory Stridor
☐ Breech Presentation	☐ Necrotizing Enterocolitis	☐ Respiratory Syncytial Virus (RSV)
☐ Bronchopulmonary Dysplasia (BPD)	☐ Negative Vacuum	☐ Transverse Presentation
☐ Cleft Lip	☐ Neonatal Hypoxia	☐ Umbilical Cord Around Neck
☐ Cleft Palate	☐ NICU (weeks): _____	☐ Use of Forceps
☐ Club Foot	☐ Oxygen Dependency	☐ Uterine Rupture
☐ Cytomegalovirus	☐ PDA	☐ Ventilator Dependency
☐ ECMO	☐ Placenta Previa	☐ VP Shunt
☐ Failure to Thrive	☐ Positive Dependency	☐ Other: _____
☐ Hyperbilirubinemia	☐ Premature Rupture of Membranes	

Medical History

Does your child have a diagnosis or any suspected diagnosis?

Does your child have any additional health issues or precautions?

☐ Cerebral Vascular Accident	☐ Reflux	☐ Traumatic Brain Injury	☐ Shunts
☐ Colic	☐ Respiratory	☐ Tube Feeding	☐ Vagal Nerve Stimulator
☐ Constipation	☐ Seizures	☐ Baclofen Pump	☐ Diabetes Mellitus Type 1
☐ Current Infection	☐ Sleep Problems	☐ Tracheotomy	☐ Diabetes Mellitus Type 2
☐ Diarrhea	☐ Cleft Palate	☐ Cleft Lip	☐ Other:

Are your child's immunizations up to date? ☐ Yes ☐ No

Current Medications

☐ Prescription: _____

☐ Over the Counter: _____

☐ Vitamin/Mineral/Dietary Supplement: _____

☐ Other: _____

☐ Not currently taking any medications:

Special Considerations

☐ Allergies: _____ ☐ Psycho-Social: _____

☐ Surgical History: Please list surgeries as (*procedure, year)*:

☐ Previous Therapy: Please list previous therapy as (*service, location, frequency)*:

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Diagnostic Testing

Test	Date	Results		Description
☐ Hearing		☐ Normal	☐ Abnormal	
☐ Vision		☐ Normal	☐ Abnormal	
☐ ABR/BAER		☐ Normal	☐ Abnormal	
☐ MRI		☐ Normal	☐ Abnormal	
☐ NCV		☐ Normal	☐ Abnormal	
☐ CT Scan		☐ Normal	☐ Abnormal	
☐ EEG		☐ Normal	☐ Abnormal	
☐ EMG		☐ Normal	☐ Abnormal	
☐ Lower GI		☐ Normal	☐ Abnormal	
☐ Motility Study/Empty Scan		☐ Normal	☐ Abnormal	
☐ Blood Work/Lab Tests		☐ Normal	☐ Abnormal	
☐ Bone Density Scan		☐ Normal	☐ Abnormal	
☐ Swallow Study		☐ Normal	☐ Abnormal	
☐ Upper Endoscopy		☐ Normal	☐ Abnormal	
☐ X-Ray		☐ Normal	☐ Abnormal	
☐ Other:		☐ Normal	☐ Abnormal	

Specialist	Name	Reason
☐ Allergist		
☐ Audiologist		
☐ Cardiologist		
☐ Endocrinologist		
☐ ENT		
☐ Gastroenterologist		
☐ Geneticists		
☐ Internal Medicine		
☐ Nephrologist		
☐ Neurologist		
☐ Oncologist		
☐ Ophthalmologist		
☐ Orthopedic Surgeon		
☐ Pediatrician		
☐ Podiatrist		
☐ Physical Medicine & Rehabilitation		
☐ Psychiatrist/Psychologist		
☐ Rheumatologist		
☐ Urologist		
☐ Vision Specialist		
☐ Other		

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Educational Information

School Attending: _____ Grade: _____

Services Received at School:

☐ PT ☐ Hearing ☐ Behavioral Assistance
☐ OT ☐ Vision ☐ Other:_____
☐ Speech ☐ Educational Support

Teacher Concerns:

☐ Motor Skills ☐ Learning Ability
☐ Social Abilities ☐ Other:_____
☐ Self-Help Skills

Behavioral Development

Frequent Mood Swings	☐ Yes	☐ No	Please list potential triggers:	
Trouble With Friendship	☐ Yes	☐ No	Particular difficulty with:	☐ Making Friends ☐ Keeping Friends
Difficulty Calming Self When Upset	☐ Yes	☐ No	Please list calming methods:	

Please indicate any additional behavioral issues:

☐ Cries Often	☐ Weak Muscles	☐ Dislikes Playground Equipment	☐ Stuttering
☐ Frequent Temper Tantrums	☐ Picky Eater	☐ Seems to be "On The Go"	☐ Able to Talk but Refuses
☐ Anxious	☐ Mouths Objects	☐ Rocks Self	☐ Aggressive to Others
☐ Trouble Following Directions	☐ Dislikes Hair Brushing	☐ Sensitive to Light	☐ Self-Injurious Behaviors
☐ Trouble with Change in Routine	☐ Dislikes Tooth Brushing	☐ Sensitive to Sound	☐ Other:_____
☐ Clumsy	☐ Avoids Others Touch	☐ Poor Attention Span	

Developmental Milestones

Please indicate below the timeframe when your child met the following milestones:

Motor Milestones:					
Held Head Up	☐ On Time	☐ Delayed	Crept/Crawled Alone	☐ On Time	☐ Delayed
Grabbed Toys	☐ On Time	☐ Delayed	Pulled Self to Standing	☐ On Time	☐ Delayed
Rolled Over	☐ On Time	☐ Delayed	Cruised Along Furniture	☐ On Time	☐ Delayed
Sat Alone	☐ On Time	☐ Delayed	Walked Unaided	☐ On Time	☐ Delayed
Speech Milestones:					
Babbled	☐ On Time	☐ Delayed	Used Two-Word Combinations	☐ On Time	☐ Delayed
Said First Word	☐ On Time	☐ Delayed	Used Complete Sentences	☐ On Time	☐ Delayed
Named Familiar Objects	☐ On Time	☐ Delayed			
Feeding Milestones:					
Breastfed	☐ Yes	☐ No	If yes, until what age?		
Used Bottle	☐ Yes	☐ No	If yes, until what age?		
Used Pacifier	☐ Yes	☐ No	If yes, until what age?		

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Activities of Daily Living

Please indicate how much assistance your child needs with the following tasks:

Removing clothes	☐ No Help	☐ 25%	☐ 50%	☐ 75%	☐ 100%
Removing socks/shoes	☐ No Help	☐ 25%	☐ 50%	☐ 75%	☐ 100%
Putting on clothes	☐ No Help	☐ 25%	☐ 50%	☐ 75%	☐ 100%
Putting on socks/shoes	☐ No Help	☐ 25%	☐ 50%	☐ 75%	☐ 100%
Tying shoes	☐ No Help	☐ 25%	☐ 50%	☐ 75%	☐ 100%
Unbuttoning, unsnapping, unzipping	☐ No Help	☐ 25%	☐ 50%	☐ 75%	☐ 100%
Buttoning, snapping, zipping	☐ No Help	☐ 25%	☐ 50%	☐ 75%	☐ 100%
Brushing teeth	☐ No Help	☐ 25%	☐ 50%	☐ 75%	☐ 100%
Washing face/hands	☐ No Help	☐ 25%	☐ 50%	☐ 75%	☐ 100%
Bathing/washing hair	☐ No Help	☐ 25%	☐ 50%	☐ 75%	☐ 100%
Toileting	☐ No Help	☐ 25%	☐ 50%	☐ 75%	☐ 100%
Wiping after toileting	☐ No Help	☐ 25%	☐ 50%	☐ 75%	☐ 100%