**PATIENT COMPLETES THIS SECTION**
Child Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_ Parent Name(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Regular Activities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Where and what is your area of Concern? (Indicate on the diagram below) and briefly describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



1. What’s your concern level on a scale from 1 to 10?

##  Mild Moderate Severe

 0. . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10

1. If there are Pain or Tantrums/behaviors, describe on a scale from 1 to 10?

## Mild Moderate Severe

 0. . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10

 4) Occurs: (Circle) Constantly Daily Weekly

Worse with: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Better with: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approx. Date this started: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dominant Hand/Foot: Right Left

5) Please list what age (**in months)** that your child achieved the following skills: Hold head up alone\_\_\_\_\_\_\_\_\_\_

Roll over \_\_\_\_\_\_\_\_\_ Sit unsupported \_\_\_\_\_\_\_\_\_ Clap hands \_\_\_\_\_\_\_\_\_ Crawl (hands & knees) \_\_\_\_\_\_\_Walk \_\_\_\_\_\_\_

**6) History/Concerns Of:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **YES** | **NO** |  | **YES** | **NO** |
| Resistance to tummy time |  |  | Locks major joints for stability  |  |  |
| History of torticollis/head tilt |  |  | W-sitting  |  |  |
| Difficulty with breastfeeding on one side compared to other  |  |  | Moves with quick bursts of activities rather than sustained effort  |  |  |
| 3-point crawling instead of on all fours  |  |  | Joints feel loose or floppy |  |  |
| Delayed milestones |  |  | Seems weaker or tires more easily than peers  |  |  |
| Significant Reflux  |  |  | Leans on objects/people for stability  |  |  |
|  Avoids activities where feet leave the ground |  |  | Poor flexibility |  |  |
|  Avoids/fear of loud sounds, bright lights |  |  | Difficulty moving from one floor surface to another |  |  |
| Stamps/slaps feet on ground when walking |  |  | "W" Sitting |  |  |
| Spillage of food/drinks from their mouth |  |  | Trips/falls with changes in surfaces |  |  |
| Lethargic or inactive, dislikes being moved |  |  | Drags feet, poor heel-toe pattern when walking |  |  |
|  Unable to alternate feet on stairs |  |  | Not able to sit upright going down a slide |  |  |

7)Does this interfere with sleeping, family, school, or sports?

8)What are the concerns of the caregiver/teacher/coach?

9) Has your child ever had this problem/concern before?

10) Does your child have an upcoming event or plans that you would like to see improvement and be better by?

9) When will you return to see the physician who referred you for this service?

**Form Completed by:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_