PHYSICAL THERAPY PRE-EXAM FORM

PATIENT COMPLETES THIS SECTION

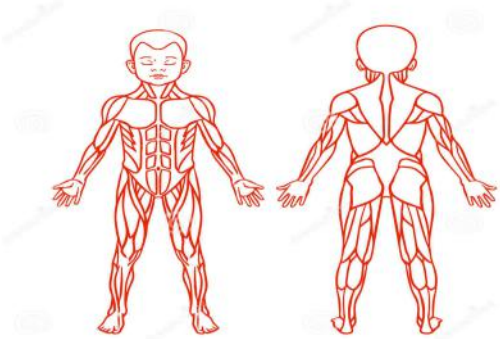
Child Name_____ Age_____ Parent Name(s)_____

Regular Activities: _____

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

_____

_____



2) 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

3) 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: _____

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**_____