PEDIATRIC PT BOSTON LLC

Childs Name:

_____

Child's Date of Birth:_____

Where is your child during the day? (school/daycare etc)

_____

Pediatricians name and phone number or email:

_____

Does or has your child see any specialists? If yes, who?

_____

_____

Birth History: For children over 2 please fill out any information that you feel is relevant

- Weeks Gestation when born:_____
- Was the pregnancy a singleton or multiples?_____
- Was your baby head down (vertex) or in a different position (like breech or transverse)?_____
- Vaginal delivery or Cesarean?
    - Any complications with delivery?_____
    - Any intervention needed (forceps/suction etc)? _____

American Board of Physical Therapy Specialties Certified Clinical Specialist

- Did your baby spend time in a special care nursery or NICU?

  _____

- Did baby need any medical interventions:

  _____

  _____

- Trouble nursing or bottle feeding?

  _____

  _____

- Did/does your baby have a head turning or tilting preference?

  _____

  _____

Medical History:

- Any history of family medical conditions or developmental conditions?

- Does your child have any diagnoses? Concerns about a potential diagnosis?

- Any concerns about their hearing or vision?

Developmental History:

When did you child first :

- Roll:

- Sit unassisted:

- Crawl on hands and knees:
- Stand:
- Walk:
- Run:
- Jump:
- Gallop:
- Skip:

  Other:

What concerns do you have for me? What are your goals? What else should I know?

I am presenting this information to the best of my knowledge and will let the practitioner know if anything changes.

Pediatric PT Boston LLC is a cash based service. We are out of network for all insurance providers. If you would like to submit to your insurance provider, you may do so on your behalf.

Parent/Guardian signature and date: _____