

Helping each client take the next step!

Patient Information	Date:
Patient's Name:	Gender: M F Other
Date of Birth:	Home Phone
Address:	
Parent Information	
Parent #1:	Parent #2:
Mobile Phone:	Mobile Phone:
Work Phone:	Work Phone:
Email:	Email:
Referring Physician	
Name/Practice:	Phone:
Address:	
Pediatrician/Primary Care Physician (C	Circle if same as above.)
Name/Practice:	Phone:
Address:	



## **New Patient Questionnaire**

Thank you for taking the time to fill out the information below so together we can create the most effective treatment plan for your child. We look forward to working with you!

Allergies:	
Medications:	Reaction:
Food:	Reaction:
<b>Birth History:</b> Child was born: Full-term Premature	_ If premature, # of weeks?
Delivery: vaginal with forceps C	-section
Were there any complications?	
Was your child placed in the Newborn Intensi	ive Care Unit (NICU)? Yes / No
For how long?	
Please describe any other medical problems o	
<b>Medical History:</b> Current Diagnosis/es:	
Hospitalizations:	
Surgeries:	
Current physician(s):	



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Current Medications:				
	uses:			
Any feeding problems or nutritional concerns?				
Other therapies your child is receiving:				
	what age your child achieved the following se which your child has not achieved yet.  Said first word			
Sat alone	Drank from a cup			
Crawled	Used a spoon			
Pulled to stand	Toilet trained			
Stood independently	Dressed self			
Walked independently	Jumped with two feet			
	2–3 goals for your child to achieve with therapy.			
1)				
2)				
3)				



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**Educational Information:** 

Present grade level: Special services received in s Does your child's teacher ha	 school: OT PT Spee ve concerns with your chi	·
Social:  Does your child interact wel		
Fears / Coping behaviors:		
Does your child have difficu	lty calming himself/hersel	f when upset? Yes / No
Additional comments:		
<b>Behavior:</b> Please circle any of the follo	wing that apply to your ch	nild.
Cries often	Anxious	Clumsy
Frequent temper tantrums	Weak muscles	Picky eater
Mouths objects	Dislikes hair brushing	Dislikes tooth brushing
Sensitive to light	Sensitive to sound	Poor attention span
Avoids touch from others	Seems to be "on the go"	Rocks self
Trouble following directions	Trouble with changes in routine	Dislikes playground equipment
What motivates your child?		
What calms your child?		
What behavior strategies do		
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