

Physical Therapy Intake Sheet

Patients Name:	D.O.B
Legal Guardian:	Today's Date:
Reason for referral:	
Known medical diagnosis:	
Past medical history:	
Any events at birth or pregnancy?	
Past surgeries:	
Caregivers concern:	
Goals you would like for your child to achieve in the future:	
Does your child attend a daycare or school?	
Age of milestones:	
Rolling:	
Crawling on all fours:	
Sitting up independently:	
Standing up:	
Walking:	
Does your child fall frequently?	
Does he become frustrated easily when he is unable to complete a task?	
Is he scared/avoids uneven surfaces?	
Is he scared/avoids high places?	
Is he regardless of his own safety?	
Does your child have a hand/foot preference?	
Does your child have any visual or hearing difficulties?	

If you have any questions or concerns, please do not hesitate to voice them at any time.