Mass General Brigham
Spaulding Rehabilitation

Date Completed: _____/_____/_____
Patient Name: _____
Date of Birth: _____/_____/_____

Physical Therapy Intake

Pregnancy and Developmental History

Was your child breech? □ Yes □ No
Were vacuum or forceps required to assist delivery? □ Yes □ No
How much time does your child spend in a swing, bouncy seat, jumper, exer-saucer or other similar pieces of equipment? _____
Does your child have a history of torticollis (head tilted or turned to one side? □ Yes □ No
Does your child have a history of w-sitting? □ Yes □ No
Does your child have a history of toe walking? □ Yes □ No
Has anyone in your family been treated for a similar condition or motor delays? □ Yes □ No
If yes, please explain: _____
_____

Precaution

Does your child have any precautions? (orthopedic, cardiac, diet, weight bearing etc.) □ Yes □ No
If yes, please explain: _____
Does your child have a shunt? □ Yes □ No
Does your child have a G-tube, G-J-tube, or colostomy? □ Yes □ No
Is your child on oxygen? □ Yes □ No If yes, how much? _____
Does your child have a history of frequent tripping or falling? □ Yes □ No
Does your child have a history of Botox injections? □ Yes □ No
If yes, when and to what muscles? _____
_____

Testing

Please indicate any medical testing the patient has received.

Test	When? By Whom?	Results:
□ MRI, X-Rays, CT scan		
□ Neuropsychology		
□ Genetics		
□ Hearing or Vision		

Equipment

Does your child have any of the following equipment or medical devices? (Please check all that apply)

□ Eyeglasses □ Walker or Crutches □ Wheelchair □ Bath/toilet chair
□ Heading Aides □ Stander/standing frame □ Gait Trainer □ Orthotics

Other

What is your child's hand dominance? □ Left □ Right
Does your child have a history of ear infections or tubes? □ Yes □ No

What are your goals for therapy? _____
_____

Parent/Guardian Signature _____ Date:_____
Relationship to patient: _____