Mass General Brigham
Spaulding Rehabilitation

Date Completed:_____

Physical Therapy Intake

Patient Information

Patient Name: _____ Date of Birth: _____

Pregnancy and Developmental History

Was your child breech? ◯ Yes ◯ No Were a 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 (sitting with their legs bent and positioned out to the sides)? ◯ 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, 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

☐ Hearing 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: _____