Physical Therapy Pre-Exam Questionnaire

In order to evaluate your condition fully, please be as accurate as possible. Thank you.

CHILD'S NAME _____

1. **What is your child's age/Date of Birth?** _____
2. **What is your child's gender?** □ Male □ Female
3. **What is your concern regarding you child?** _____

_____

4. **Has your child had Physical Therapy before?** □ Yes □ No
5. **Where is the problem?** _____
6. **What caused the problem?** _____
7. **Approximately when did it start?** ____/____/20_____
8. **Is it getting worse, better, or staying the same?** _____
9. **Are all immunizations up to date?** □ Yes □ No

10. **Is your child on any medication for this problem?** □ Yes □ No

    - If yes, what and does it help?

11. **Any vision or hearing problems?** □ Yes □ No

    - If yes, describe how.

12. **Has been evaluated by a specialist other than the Pediatrician?** ☐**Yes** ☐**No**

    If yes please list: _____

    _____

13. **List all past surgeries with dates:**

15. **Comments:** _____

Patient Name:_____

Signature:_____ Date:_____

Physical Therapist Initials_____