

PEDIATRIC PHYSICAL THERAPY INTAKE

For children and adolescents ages 3–15 years

1 | CHILD & FAMILY INFORMATION

Child's full name	Preferred name	Date of birth / age
Parent / guardian	Relationship	Phone
Email	Home address	School / daycare

2 | BIRTH HISTORY

Gestational age: _____ weeks ☐ Full term ☐ Premature Birth weight _____ lb / oz

Delivery: ☐ Vaginal ☐ C-section NICU stay? ☐ No ☐ Yes — length / reason: _____

Pregnancy / birth complications or early concerns: _____

3 | REFERRAL & REASON FOR VISIT

Referring provider	Provider phone / fax	Primary care provider

What brings your child to PT? Check all that apply.

☐ Balance / falls	☐ Coordination
☐ Walking / running	☐ Toe walking
☐ Weakness / low endurance	☐ Gross motor delay
☐ Pain	☐ Stairs / playground access
☐ Posture / alignment	☐ Sports / activities
☐ Orthotics / equipment	☐ Surgery / injury
☐ Neurologic condition	☐ Other: _____

4 | MEDICAL & DEVELOPMENTAL HISTORY

Diagnoses / medical conditions: _____

Medications	Allergies

Has your child lost a skill they previously had? ☐ No ☐ Yes — explain: _____

MOBILITY & EVERYDAY ACTIVITIES

5 | MOBILITY STATUS

How does your child usually move around? Check all that apply.

- | | |
|--|--|
| ☐ Walks independently | ☐ Needs supervision to walk |
| ☐ Needs physical help to walk | ☐ Walker / gait trainer |
| ☐ Crutches / cane | ☐ Wheelchair |
| ☐ Adaptive stroller | ☐ Crawls / scoots |
| ☐ Help with transfers | ☐ Help with stairs |
| ☐ Frequent falls / trips | ☐ Balance difficulty |
| ☐ Coordination difficulty | ☐ Low walking endurance |
| ☐ Pain affects mobility | ☐ Limp / uneven walking |
| ☐ Toe walks | ☐ Other: _____ |

6 | ORTHOTICS & EQUIPMENT

What does your child use? Check all that apply.

- | | |
|---|---|
| ☐ AFOs | ☐ SMOs |
| ☐ Foot orthotics / inserts | ☐ Brace (knee, hip, or trunk) |
| ☐ Night / stretching splints | ☐ Manual wheelchair |
| ☐ Power wheelchair | ☐ Adaptive stroller |
| ☐ Walker / gait trainer | ☐ Crutches / cane |
| ☐ Stander / standing frame | ☐ Bath / toilet / transfer equipment |
| ☐ Adaptive seating | ☐ Other: _____ |
| ☐ None | |

Equipment / orthotic provider

Prescribing provider

Frequency of use:

- ☐ Daily
 ☐ At school
 ☐ Longer distances
 ☐ As needed
 ☐ Not currently used

Fit, comfort, skin concerns, or reason for use:

EVERYDAY ACTIVITIES & MOVEMENT

7 | EVERYDAY ACTIVITIES, MOVEMENT & GROSS MOTOR SKILLS

Skills are listed from foundational movement to more advanced coordination and agility.

Mark whether your child can do each skill and whether it is a challenge / not yet.

ACTIVITY / SKILL	CAN DO	CHALLENGE / NOT YET
Sitting balance / maintaining upright posture	☐	☐
Rolling / moving between lying and sitting	☐	☐
Getting up from floor / chair	☐	☐
Standing balance without support	☐	☐
Squatting down and standing back up	☐	☐
Transfers (bed, chair, car, toilet)	☐	☐
Walking independently on level surfaces	☐	☐
Walking up / down stairs	☐	☐
Using stairs / curbs safely in the community	☐	☐
Walking longer distances / community outings	☐	☐
Running	☐	☐
Changing direction while running	☐	☐
Jumping forward with two feet	☐	☐
Jumping down and landing safely	☐	☐
Balancing on one foot	☐	☐
Hopping on one foot	☐	☐
Skiping / step-hop	☐	☐
Gallopig / side-stepping	☐	☐
Bear crawling / animal walks	☐	☐
Climbing playground equipment	☐	☐
Pedaling a tricycle / riding a bike or scooter	☐	☐
Catching and throwing a ball	☐	☐
Coordinating movement during games / sports	☐	☐
Jumping jacks	☐	☐
Agility ladder drills / quick footwork	☐	☐
Keeping up with peers during active play	☐	☐
Participating in PE / playground / preferred activities	☐	☐
Other: _____	☐	☐

Additional notes about daily activities or movement:

INTERESTS, GOALS & COMMUNICATION

8 | THINGS MY CHILD ENJOYS

Favorite toys, games, activities, sports, characters, or interests:

What motivates your child or helps them feel comfortable during new activities?

9 | FAMILY GOALS

What would you most like your child to improve or be able to do?

10 | COMMUNICATION & THERAPY SUPPORTS

How does your child communicate? Check all that apply.

☐ Speaks in sentences

☐ Gestures / signs

☐ Picture symbols

☐ Other: _____

☐ Uses words / short phrases

☐ Communication device / AAC

☐ Limited verbal communication

Current or previous therapies:

☐ PT

☐ Speech therapy

☐ Early intervention

☐ Other: _____

☐ OT

☐ ABA / behavioral therapy

☐ School-based services

☐ None

Anything that helps us communicate with or support your child?
