Made To Move
physical therapy, inc

Infant / Child Medical History

Please completely fill out the following questions. This will assist us in properly treating your child and identifying possible contraindications for certain treatments. All information is held in strict confidence.

Child's Name: _____ Date of birth: _____

Parents Name (s): _____

Name of Referring Doctor: _____

Reason for referral/Parental Concerns: _____

_____

Birth History

Child born at _____ weeks gestational age.

Mother's pregnancy: Normal ☐ Yes ☐ No

If no please explain: _____

_____

Complications during delivery: ☐ Yes ☐ No Delivery: ☐ Vaginal ☐ C-section

If yes please explain: _____

_____

Did your child require a stay in the NICU? ☐ Yes ☐ No If so how long? _____

Medical History

Did you child pass their newborn hearing screen: ☐ Yes ☐ No

Are immunizations up to date: ☐ Yes ☐ No

Previous Hospitalizations: _____

Please list any medications your child is currently taking: _____

_____

Does your child have any medical diagnosis and if so what age was it diagnosed? _____

_____

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615 North Nash Street, Suite # 306 El Segundo, CA 90245 (310) 535.0008 FAX (30) 535.0009
info@madetomovept.com

Has your child ever been seen by a medical specialist (ex. Orthopedist, neurologist) If yes, please describe:

_____

_____

Does you child have any allergies, seizures or use any special equipment such as glasses or hearing aids?

_____

Developmental History

Please give approximate age when your child reached the following milestones:

Roll belly to back	
Roll back to belly	
Sit alone	
Crawling	
Walking	
Babbling	
Using Single words (eg. No, mom, doggie)	
Combine words (eg. Me go, daddy shoe)	
Finger feeding	
Eat from a spoon	
Drink from an open cup	

Are there any eating concerns with your child at the moment? _____

_____

Goals for physical therapy: _____

_____

_____

Parent's Signature: _____ Date: _____

(Note: insurance carriers require a signature)

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