



**PEDIATRIC NEW PATIENT FORM**

Name \_\_\_\_\_ Date \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Physician \_\_\_\_\_ Diagnosis \_\_\_\_\_  
\_\_\_\_\_

Parent / Gaurdian's Name \_\_\_\_\_  
\_\_\_\_\_

Were there any problems during pregnancy or delivery?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have there been any hospitalizations since birth? Reason for hospitalization?

\_\_\_\_\_  
\_\_\_\_\_

When was the current problem first noted?

\_\_\_\_\_

Is your child in any pain? If yes, please describe where & when pain occurs.

\_\_\_\_\_  
\_\_\_\_\_

At what age did your child do the following?

Roll \_\_\_\_\_ Walk \_\_\_\_\_

Sit Alone \_\_\_\_\_ Hold Bottle \_\_\_\_\_

Crawl \_\_\_\_\_ Feed Self \_\_\_\_\_

Stand with Help \_\_\_\_\_ Dress Self \_\_\_\_\_

Stand Alone \_\_\_\_\_

Is your child on any medication?

---

Does your child have any other medical problems, i.e. seizures, asthma, allergies?

---

Does your child have any equipment or braces? If yes, are they in need of any new equipment or braces? Please list.

---

---

---

Is your child receiving therapy now? Has she/he received therapy in the past? Please list where & when therapy was/is being received.

---

What are your goals for therapy?

---

---