Pinnacle Kidz
Pediatric Physical Therapy

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DATE ____/____/_____

# New Patient Questionnaire

**Patient Name:** _____ **Sex:** _____ **Date of Birth:** _____

**Birth/Medical History:**

**Was your child born term/preterm? (circle)** **If preterm, gestational age at birth:** _____

**Vaginal birth/C-section (circle)** **Apgar scores at birth (if available):** _____

**List any complications during labor/delivery:** _____

**Did your child require a NICU stay after birth? Yes/No (circle)** **If yes, how many days:** _____
**What treatments were provided?** _____

**Has your child been diagnosed with any medical conditions? Yes/No (circle)**
**If yes, please list:** _____

**Is your child under the care of any specialist physicians? Yes/No (circle)**
**If yes, list physician/specialty/reason:** _____

**Is your child currently taking any medications? Yes/No (circle)** **If yes, please list:** _____

**Has your child been recently hospitalized? Yes/No (circle)** **If yes, when/why:** _____
_____

**Has your child received any therapies in the past for this diagnosis? (i.e. PT, OT, Speech, etc.)** **Yes/No (circle)**
**If yes, please list where/when/outcome:** _____
_____

**What is your primary concern for initiating physical therapy?** _____

**What are your goals for physical therapy treatment?** _____

**Please list any favorite toys/activities/special interests/strengths that might help us to connect with your child:** _____
_____

**Please list any questions/comments you would like to share with your child's therapist:** _____
_____

**How did you hear about us?** _____