CLEARWATER PHYSICAL THERAPY

Pediatric Registration Form

Child's name: ________________________ **Parent's Names:** __________________________

Phone Number: _______________________ **E-mail:** _________________________________

Address: ____

Date of Birth: ______________ **Age:** _________________ **Sex:** ___________________

Child's Diagnosis: ____

Does your child attend daycare, a preschool program, or school? ______________________

Name of school or program: ____

Does your child receive Program Unit Funding (PUF)? ___________________________

Contact person at school: ____

Why is your child being referred to Clearwater Physical Therapy Pediatric Program?

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When was this condition first noticed? ____

Medical History:

Child's birth weight: _________________ Due date: _____________________

- ☐ **Premature (less than 38 weeks)**
- ☐ **Mature (38-42 weeks)**
- ☐ **Overdue (over 42 weeks)**

<u>**Please answer the following questions:**</u>

1. **Problems during pregnancy of delivery: (ex. Breech/caesarean section/other)**

2. **Condition at birth:**

3. **Any Respiratory problems at Birth: Yes/No**

4. **Any abnormalities at Birth: Yes/No**

5. **Does your child have any recurring medical problems? Yes/No**

6. **Is your child currently taking any medications, vitamins, herbs? Yes/No**

7. **Are your child's immunizations up to date? Yes/No**

8. **Has your child had any surgical or other medical procedures? Yes/No**

9. **Has your child ever had a seizure: Yes, Frequency: ______________ No**
   ☐Uncontrolled ☐Controlled by medication

10. **Does your child have asthma? Yes/No**
11. **Does your child have allergies? Yes/No**
12. **Do you have any feeding concerns with your child? Yes/No**

Explain:

13. **Do you have any sleeping concerns with your child? Yes/No**

Explain:

14. **Do you have any concerns regarding your child's vision? Yes/No**

15. **Has your child's vision been checked recently?** ☐Yes ☐ No

Results: ☐ Normal ☐ Wears glasses ☐ Problems with vision:

16. **Do you have any concerns with your child's hearing? Yes/No**

17. **Has your child's hearing been checked?** ☐ Yes ☐ No

Results: ☐ Normal ☐Problems with hearing:

18. **Has your child had ear infections: Yes/No ☐ More than 3:**

19. **Does your child have tubes in his/her ears? Yes, date: __________ No**

20. **Do you have any concerns with your child's behavior?**

21. **Any family history or development delays or diagnosis in your (mom/dad) family?**