KREMER Physical Therapy

PATIENT HISTORY INTAKE

Demographics and Referral

- **Child's Name: _____**
- **Child's DOB: _____**
- **Child's Address: _____**
- **Sex: _____**
- **Preferred pronouns: _____**
- **Person providing information: _____**
  - **Email: _____**
  - **Relationship to child: _____**
- **Reason for referral and who referred: _____**
- **Parent main concerns at this time: _____**
  _____

Birth History (if known):

- **Is child adopted? _____(*If yes, please fill out any known birth or pregnancy history)***
- **Pregnancy issues: _____**
- **Length of labor: _____**
- **Place of delivery: _____**
- **Gestational age at time of birth:_____**
- **Delivery (C section, vaginal, emergency) _____**
- **Birth weight/length : _____**
- **Assist during birth (forceps, vacuum, etc) _____**
- **Birth presentation (sunny side up? Cord wrapped anywhere?):**
  _____
- **Any other issues noted during delivery (brachial plexus injury, collar bone injury, jaundice):**
- **Did newborn require extended hospital stay? NICU? _____How long? _____**
- **Describe interventions provided: _____**
- **Describe support/monitoring needed upon discharge: _____**
- **Did baby or mother require extended hospital stay? How long & explain:**
  _____ _____

Newborn hearing test at birth? Passed? _____ Any follow up needed? _____

Medical History/Systems review

- **List any diagnoses your child has: _____**
- **Vision screening? _____**
- **Immunizations up to date? _____**
- **Communicable diseases? _____**
- **Please check any concerns below:**
  - **Seizures:_____ Shunt:_____ Head injury/ Concussion: _____**
  - **Feeding: _____ Tube:(NG,GT,JT) _____ Aspiration/Pneumonia: _ ____**
  - **Reflux: _____ Constipation: _____ Gagging/choking: _____**
  - **Ear Infections:_____ PE Tubes: _____ Hearing aid/Cochlear Imp: _____**
  - **Speech delay: ____ loss of words _____ Hard to understand _____**
  -
- **Systems check (*please check any areas of concern and explain below)*:**
  - **Bowel/Bladder:___ Brain:___ Digestion: ___**
  - **Heart (murmurs,holes,hernia) _____ Respiratory ___**
  - **Sensory: _____ Skeletal:____ Skin: ____**
  - **Lungs: _____ Kidney: _____**

  Explanations:_____

_____

- **Frequency of BMs:_____**
- **Was baby Jaundice? _____**
  - **What interventions were required and for how long: _____**
    _____
- **Any other health concerns? _____**
- **List any tests (swallow study), procedures, hospitalizations, surgeries child has had or is scheduled to have:**
  _____
  _____
  _____
- **Allergies and sensitivities _____**

Gross Motor Milestones **Communication Milestones**

(please list age milestones were met)

- **Holding head up: _____** **Cooing (vowel sounds) _____**
- **Tummy tIme: _____** **Babbling (consonant sounds)_____**
- **Rolling back to belly: _____** **Responding to name _____**
- **Rolling belly to back : _____** **Following simple directions _____**
- **Sitting alone: _____** **Imitating sounds _____**
- **Crawling on belly: _____** **Saying single words _____**

- **Crawling on hands and knees: _____** **Saying phrases _____**
- **Pulling to stand: _____** **Saying Sentences _____**
- **Cruising :_____**
- **Standing: _____**
- **Walking without support: _____**

Therapies

- **List any previous therapies: _____**
- **List any current therapies: _____**

Other professionals involved with your child

- **Allergist:_____**
- **Chiropractor: _____**
- **CST:_____**
- **Dentist: _____**
- **Doula: _____**
- **ENT: _____**
- **GI: _____**
- **Lactation Consultant: _____**
- **Neurologist: _____**
- **Nutritionist/Dietician: _____**
- **Orthopedist: _____**
- **Pediatrician: _____**
- **Specialists: _____**
- **Therapists: _____**
- **Other: _____**

Medications:

Please list all medications (include dosage and purpose of med) your child is currently taking:

_____
_____
_____
_____

Daily Life

- **List all the people living in your home: _____**
  _____

- **School/Education/Regular child care situation**
  - **Home with Caregiver: _____**
  - **Daycare: _____**
  - **School: _____**

*****PLEASE COMPLETE THE FOLLOWING IF YOU ARE BEING SEEN FOR FEEDING THERAPY*****

FEEDING INTAKE

General

- **What is the current weight and height of your child: _____**
- **What are your main feeding concerns for your child: _____**
  _____
  _____
  _____
- **Do you have concerns about your child's safety while eating:**
  _____
  _____
- **Are there any precautions we should be aware of when working with your child:**
  _____
  _____
- **Please check any goals you have for your child's feeding:**
  - **Increase volume/variety _____ Increase textures of foods _____**
  - **Increase weight gain _____ Decrease/eliminate Tube feeding_____**
  - **Decrease gagging, vomiting related to eating _____**
  - **Improve oral motor skills _____**
  - **Transitioning to solids _____ Others _____**

Nutrition History

My child needs additional nutritional support:
Calorie Booster _____ Specialized Diet _____ Appetite Booster _____
My child has a history of: Poor weight gain _____Slow Growth Rate _____

- **Failure to thrive_____ Excessive weight gain _____ Aspiration pneumonia ___**
  Tube feeding (NG,GT,JT) _____ Eczema _____ Frequent vomiting _____

My child is working with a Registered Dietician, Nutritionist, Feeding Therapist _____
Please list any food allergies or intolerances: _____

Oral Motor

- **Please check all that apply**
  - **Drools _____ Open Mouth resting posture _____ High Palate_____**
  - **Chronic Congestion _____ History of Tongue Thrush _____**
  - **Rests Tongue between lips _____ Coughing/choking on saliva _____**
  - **Food refusal _____ Gagging and/or vomiting _____**

- **Noisy breathing _____** **Tethered oral tissues _____**
- **Mouths toys/objects/fingers _____** **Pacifier use (how long) _____**
- **Snoring _____** **Poor sleep pattern _____**

- **Does your child tolerate tooth brushing _____**

Feeding History

- **How does your child currently eat _____**
  - **Breast _____ Bottle _____ Solids _____**
- **Symptoms noticed during feeding**

  _____
  _____
  _____
- **If you are currently breast and/or bottle feeding:**
  - **How Often _____ Frequency _____ What liquid _____**
  - **How much _____ Bottle Brand _____ Nipple brand _____**
- **Describe any difficulties with bottle feeding**

  _____
  _____
- **Is your child using alternative nutrition methods (check all that apply)**
  - **NG (Nasogastric Tube) _____** **GT (gastronomy tube) _____**
  - **TPN (total parenteral nutrition) _____** **JT (Jejunostomy tube) _____**
- **Describe below**
  - **Formula/recipe _____**
  - **Schedule _____**
  - **Volume/rate _____**
  - **Delivery (bolus or pump) _____**
- **At what age were solids introduced _____**
- **List any favorite foods: (Brands specific?)**

  _____
  _____
- **List foods your child avoids or refuses:**

  _____
  _____
- **List drinks, liquids: _____**
- **My child uses: spoon, fork, sippy cup, straw cup, open cup, straw, water bottle, baby bottle, other: _____**