Physical Therapy Solutions Pre-Exam Questionnaire

In order to evaluate your child's condition fully, please be as accurate as possible. Thank you.

1. **Child's age?** _____

2. **Child's gender?** ☐ Male ☐ Female

3. **Had physical therapy before?** ☐ Yes ☐ No

4. **Child's problem?** _____

5. **What caused the problem?** _____

6. **Approximately when did it start?** ____/____20_____

7. **Is it getting worse, better , or staying the same?** _____

8. **Immunizations up to date?** ☐ Yes ☐ No

9. **Any allergies?** ☐ Yes ☐ No

10. **Vision problems?** ☐ Yes ☐ No

11. **Hearing problems?** ☐ Yes ☐ No

12. **Any contagious conditions?** ☐ Yes ☐ No

13. **Taking any medications?** ☐ Yes ☐ No

    Please list: _____

14. **Has been evaluated by a specialist other than the Pediatrician?** ☐ Yes ☐ No

    Please list: _____

15. **Any diagnostic studies performed (CAT scan, MRI, Xray)** ☐ Yes ☐ No

    Please list: _____

16. **Any past surgeries?** ☐ Yes ☐ No

    Please list: _____

Thank you for your thoroughness.

Parent/ Caregiver Name: _____

Signature: _____ Date:_____

Physical Therapist Initials_____