NEWBURY PARK
PHYSICAL THERAPY

2814 Camino Dos Rios, Suite 406
Newbury Park, CA 91320
T: 805.375.1461
F: 805.498.7613
www.nppt.com

Pediatric Patient Information

Patient's Name _____ DOB _____ Age _____ Gender: ◯M ◯F

Parent's Name: _____ Contact Number: _____

Current Height/Weight Percentile: _____ Length of Hospital Stay: _____ Apgars: _____ Birth Order: _____

Gestational Age: _____ Was child born prematurely? ◯YES ◯NO If yes: Chronological Age: _____

Mom's age at time of birth: _____

Name of Hospital / Birth Center Child was born: _____

Ob/GYN &/or Mid-Wife: _____

Was your child admitted to NICU or did he/she remain in newborn nursery / your room? _____

Did your child receive therapy service prior to returning home (in NICU, PICU, or nursery)? ◯YES ◯NO

Utero Position (if known): _____ Was infant active in utero? ◯YES ◯NO

Infant position at birth: ◯Vertex ◯Breech ◯Transverse ◯Other: _____

How long in Delivery: _____ How long did you push? _____

◯Vaginal ◯C-Section ◯Forceps ◯Vacuum ◯Nuchal Cord ◯Other: _____

Did the infant seem stuck in one position for the last part of the pregnancy? ◯Yes ◯No

How many weeks was the infant stuck? ◯Vertex ◯Breech ◯Transverse _____ Weeks

First Child? ◯YES ◯NO ◯Single ◯Multiple Birth: ◯Twin A ◯Twin B

List any complications during pregnancy (bed rest/low back pain/ leg pain): _____

List any complications during delivery: _____

Has child ever been treated for torticollis? ◯YES ◯NO

Has child ever been treated for any other diagnosis? ◯YES ◯NO if so, please name _____

Known Uterine Abnormalities? ◯YES ◯NO Describe: _____

DiagnosticTest: ◯ XRAY ◯ MRI ◯ CTSCAN ◯US ◯SWALLOWING STUDY ◯VISION STUDY

Does your child have frequent ear infections? ◯YES ◯NO

Was child breastfed? ◯YES ◯NO Length of time: _____

Did your infant have trouble feeding? ◯YES ◯ NO (breast: left / right; bottle feeding, tongue tie)

Jaundice? ◯YES ◯ NO Reflux? ◯YES ◯ NO Medication: _____

What kind of food/formula does your child eat? _____

Does child have sensitivities? ◯YES ◯NO If yes, _____ (i.e., sounds, textures, etc.)

Where do you generally seek information on your child's development? _____

Did your infant have normal head shape at birth? ◯ YES ◯ NO if no, describe. _____

Who noticed the misshapen head? _____ What age? _____

Time child spends in car seat per day: _____ Type used: _____

Time child spends in swing per day: _____

Other infant sitting devices used and time per day: _____

Childs mealtime position: highchair ____ booster seat____ car seat.____ bumbo ____ Other: _____

Child's sleep position (birth-1yr): Supine (on back) ____Side ____ Prone (on tummy) Other: _____

Time child spends on back daily: _____ Time child spends on belly daily: _____

Belly increments per day: _____ Age initiated Belly time: _____

How often is baby held?_____ What position? _____

Does your infant have a head tilt preference: ◯ LEFT ◯ RIGHT Rotation preference: ◯ LEFT ◯ RIGHT

Any other children with tight neck muscles and/or misshapen head? ◯ YES ◯ NO

Do you notice any facial asymmetry? ◯ YES ◯ NO Describe: _____

Congenital anomalies:

Hip dysplasia/ hip subluxation: ◯ LEFT ◯ RIGHT

Fractured Clavicle: ◯ LEFT ◯ RIGHT

Forceps abrasion: ◯ LEFT ◯ RIGHT

Facial Palsey: ◯ LEFT ◯ RIGHT

Brachia! Plexus Injury: ◯ LEFT ◯ RIGHT

Ceph.alohematoma: Parietal - ◯ Left ◯ Right ◯ Small ◯ Medium ◯ Large

Occipital - ◯ Left ◯ Right ◯ Small ◯ Medium ◯ Large