NEWBURY PARK
PHYSICAL THERAPY

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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 labor? _____ How long did you push? _____

Delivery: ☐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: _____

Diagnostic Test: ☐XRAY ☐ MRI ☐CT SCAN ☐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

Brachial Plexus Injury: ☐ LEFT ☐ RIGHT

Cephalohematoma: Parietal - ☐ Left ☐ Right ☐ Small ☐ Medium ☐ Large

Occipital - ☐ Left ☐ Right ☐ Small ☐ Medium ☐ Large