

**Parent Information Form
Physical Therapy**

Child's Name _____ Date of Birth _____ Sex: M F

Parent's Names _____

Street Address _____

City, State, ZIP Code _____

Phone Number (Home) _____ Can we leave a message? Yes No

Cell or Alternate Number _____

Mother's Work Phone _____ Father's Work Phone _____

Insurance Company _____

Other Funding Source _____

Pediatrician _____ Phone _____

Address _____

Who referred you to the St. John's Mercy Child Development Center? _____

Reason for referral _____

Concerns

In what areas do you have concerns? Please list specific concerns you have observed.

Diagnosis _____

Please list any other professionals consulted for your child (i.e., neurologist, psychologist, orthopedist, nutritionist, ENT, GI)_____

Medical History

Describe any problems experienced during this pregnancy_____

Hospital where child was born_____

Length of labor_____Type of delivery_____

Was this a single birth?_____Birth weight_____

Describe baby's condition at birth and/or while in the hospital nursery_____

How long did the baby remain in the hospital?_____

List any serious illness, surgery, or accidents requiring medical treatment_____

Date of child's last physical examination_____Results_____

Is your child allergic to any foods or substances? If yes, please list_____

List any medications your child is now taking: prescriptions, over-the-counter, vitamins, or herbal supplements.

Medication	Dosage	Doctor Prescribing
_____	_____	_____
_____	_____	_____
_____	_____	_____

Thank you very much for providing this information. It will be helpful in evaluating your child.