TAYLOR
PHYSICAL THERAPY

Patient Sticker

Child's Legal Name: _____ **DOB**: _____
Age: _____ Male: _____ Female: _____
Child's primary care physician: _____
Primary Address: _____
Child's primary language: _____
Any additional languages spoken in the home: _____

Guardian 1 Name: _____ **Guardian 2 Name:** _____
Primary Phone: _____ Primary Phone: _____
Email: _____ Email: _____

Child currently resides with? _____

If primary person bringing child to therapy is not listed above, please list name and contact phone number of that person.
_____

MEDICATION/ALLERGY/CONDITION FORM

Medication: Please include prescription drugs, over-the-counter medications, vitamins, and homeopathic medications.
_____
_____
Allergies/Reactions: _____
_____
Diagnosis: Please indicate any medical diagnosis or medical condition, with dates if known.
_____
_____

List the names of the programs and people that have worked or are working with your child outside of Taylor Physical Therapy.
If your child has an IEP through his/her school, please bring us a copy for our records.

Service	Program Name	Teacher/Therapist	Phone#	Dates
Child Care				
School				
OT				
PT				
Speech				
Psychology				
Counseling				
Caseworker				
Dietitian				
Specialty Dr.				
Other				

I hereby authorize any prior or present treating physician, therapist, school, hospital, or other health institution, to release all medical information by any means of communication to Taylor Physical Therapy. I also hereby authorize treatment to be administered after evaluation according to the therapist's discretion.

Signature of Parent or Guardian: _____ *Date:* _____

WAVERLYHEALTH CENTER

Patient Sticker

Was this child a Natural Birth or C-Section? _____

Was your child full term? If not, please give gestational age. _____

Were there any injuries, illnesses, or additional complications during pregnancy or labor? If yes, please describe.

_____

_____

How would you describe your child's overall health? Please list any significant medical conditions, surgeries, illnesses, etc.

_____

_____

When did you first become concerned about your child's development?

_____

_____

Please describe the concerns with your child's speech and language development.

_____

_____

Has your child received speech-language therapy in the past? If yes, please describe what skills your child was working on and any strategies that worked well for your child/family.

_____

_____

Approximately how many words does your child consistently say on his/her own? _____

What is your child's primary mode of communication? (Circle all that apply)

Verbal *Nonverbal* *Sign language* *Gestures* *Pointing* *AAC device*
PECS *Other:* _____

Has your child's hearing been evaluated recently? If yes, what were the results?

_____

_____

Has your child's vision been evaluated recently? If yes, what were the results?

_____

_____

Family history of speech and/or language concerns: _____

Does your child have a history of any of the following? (Circle all that apply)

Ear infections *PE tubes* *Cleft Palate/Lip* *Gastroesophageal Reflux*
Seizures *Vision problems* *Feeding tube* *Developmental Delay*

How much of your child's speech do ***you*** understand? (Circle one)

10% or less 11-24% 25-50% 51-74% 75-100%

How much of your child's speech do ***others*** understand? (Circle one)

10% or less 11-24% 25-50% 51-74% 75-100%

Does your child demonstrate frustration when he/she is not understood? (Please explain)

_____

_____

What are your goals for your child?

Short term_____

Long term_____