Allied Rehab
Speech, Occupational & Physical Therapy

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PHYSICAL THERAPY HISTORY FORM

Child's Name _____ Current Age _____

What are your child's strengths?_____

_____

Milestones:

What age did your child begin these activities?

rolling? _____ sitting? _____ crawling? _____ creeping? _____ standing?_____ walking? _____

Adaptive Equipment:

Does your child currently need to use any special equipment? Yes ☐ No ☐

What equipment do you already have? _____

_____

What items would you like to have? _____

_____

Do you think your child has problems with any of the following? Please check all that apply.

- ☐ Ambulation (walking)
- ☐ Functional mobility (moving for simple tasks like reaching/dressing/eating)
- ☐ Posture (sitting or standing straight)
- ☐ Range of motion of (full use of arms, legs, or turning/tilting/lifting head)
- ☐ Strength
- ☐ Balance
- ☐ Coordination
- ☐ Pain - If Yes, Where is the pain?_____
- ☐ Other: _____