Physical Therapy Solutions Pre-Exam Questionnaire

In order to evaluate your child's condition fully, please be as accurate as possible. Thank you.

1. **Child's age?** __________
2. **Child's gender?** ☐ Male ☐ Female
3. **Had physical therapy before?** ☐ Yes ☐ No
4. **Child's problem?** ________________________
5. **What caused the problem?** ________________________
6. **Approximately when did it start?** ____/____20_____
7. **Is it getting worse, better , or staying the same?** ________________________
8. **Immunizations up to date?** ☐ Yes ☐ No
9. **Any allergies?** ☐ Yes ☐ No
10. **Vision problems?** ☐ Yes ☐ No
11. **Hearing problems?** ☐ Yes ☐ No
12. **Any contagious conditions?** ☐ Yes ☐ No
13. **Taking any medications?** ☐ Yes ☐ No

    Please list: ____
14. **Has been evaluated by a specialist other than the Pediatrician?** ☐ Yes ☐ No

    Please list: ____
15. **Any diagnostic studies performed (CAT scan, MRI, Xray)** ☐ Yes ☐ No

    Please list: ____
16. **Any past surgeries?** ☐ Yes ☐ No

    Please list: ____

Thank you for your thoroughness.

Parent/ Caregiver Name: ____________________________________

Signature: ____ Date:_______________

Physical Therapist Initials___________