

CHILD'S NAME: _____ DATE OF BIRTH: _____

PHYSICAL THERAPY (PT) QUESTIONS:

Please answer the appropriate questions for the child's **current age**:

0-2 years:

- Can child hold head in midline? Y N *If not, what side does it tilt to?* Left Right
- Does patient walk up on toes? Y N

2-4 years of age:

- Can child hop/ jump without Falling? Y N
- Can child throw/ catch a ball? Y N
- Can child ride a tricycle? Y N

5-9 years of age:

- Can child ride bike with/without training wheels? Y N
- Can child jump rope 2-3 times? Y N
- Can child balance on one leg for 10 seconds? Y N
- Can child jump & run in rhythm to simple tunes? Y N

For ALL Ages:

Does child have balance issues? Y N *If Yes, please explain:* _____

Does child complain of pain? Y N *If Yes, where is pain located/what makes it worse?* _____

Was there any accident/injury that caused the current problem? Y N *If Yes, please explain:* _____

Any activity restrictions due to skeletal Anomalies (i.e. atlanto-axial instability)? _____

FAMILY CONCERNS/GOALS:

Please list YOUR PT concerns:

Please list YOUR PT goals for the child for the next SIX months:
