



New Patient _____
Current Patient _____

PATIENT INFORMATION

MAILING ADDRESS

P. O. Box 17630
Louisville, KY 40217

CENTRAL CAMPUS

982 Eastern Parkway
Louisville, KY 40217
(502) 635-6397

EAST CAMPUS

9810 Bluegrass Parkway
Louisville, KY 40299
(502) 584-9781

www.kidscenterky.org

USE INK PEN TO COMPLETE

Date: _____

Person providing information: _____

Relationship to child: _____

Child's Name: _____ DOB: _____ Sex: _____

1. Reason for Referral:

2. What are your main concerns for your child at this time?

3. What skills would you like for your child to improve that are related to **Physical therapy**:

gross motor balance & coordination joint mobility equipment
 mobility posture other _____

Specific comments: _____

4. If interested in **Occupational Therapy**, please complete attached O.T. questionnaire.

5. If interested in **Speech Therapy**, and/or **Feeding**, please complete attached S.T. questionnaire.

Previous History

6. Birth History

Hospital: _____ Full Term Premature How early? _____

Delivery: C-section Vaginal Birth weight: _____

Birthing Assistance: Forceps Suction

Birth Presentation: cephalic (head first) breech shoulder nuchal cord

Did you or your child experience any problems during your pregnancy or delivery? _____

Did he/she require an extended hospital stay after delivery? yes no How long? _____

Was your child adopted? yes no If yes, at what age? _____, and from what country? _____

Proud partner of



Kids Center for Pediatric Therapies is a 501c3 nonprofit corporation.

Your gifts are tax-deductible to the extent allowed by law.

7. Relevant Medical History

Please list all diagnoses that your child has:

Does your child have a history of seizures? yes no If yes, what type? _____

Does your child have a shunt? yes no If yes, what type? _____

Does your child have feeding issues? yes no

Does your child have a G-tube yes no

Has your child had a swallow study? yes no If yes, when & where? _____

Did your child receive newborn hearing screening at birth? yes no

Has your child had a hearing test (audiological evaluation)? yes no

Has your child been diagnosed with a hearing loss? yes no

Does your child wear a hearing aid? yes no

Does your child have a history of ear infections? yes no

Does your child have ear tubes? yes no previously, but not currently

If previously, when were they placed? _____

Has your child ever had a head injury or concussion? yes no If yes, explain what happened and when: _____

Does your child have a Baclofen pump? yes no If yes, when was it placed?

What physician did the surgery to place it? _____

Who monitors the dosage? _____

Who does the pump refills? _____

Are your child's immunizations up to date? yes no If no, what does he need?

Has your child had any communicable disease? yes no If yes, what disease: _____

Other than the above, what other health problems does your child have? (Please describe)

8. Please list all test/procedures, hospitalizations and surgeries that your child has had: (include year and surgeon)

9. **Allergies:** Please list all allergies and/or sensitivities:

10. **Developmental Motor Milestones:**

Please indicate which of the following motor milestones your child has achieved and at what age it occurred:

- Holding head up _____
- Rolling _____
- Sitting alone _____
- Crawling (belly or hands & knees) _____
- Pulling to stand _____
- Cruising (walk at furniture) _____
- Standing (no external support) _____
- Walking (no external support) _____

11. **Previous Therapies:** Please list all previous therapies & include approximate date of last visit

12. **Relevant Family History:**

Please list any family members with the same or similar diagnosis as your child:

Other relevant family medical history: _____

Current Profile:

1. Provide Name of other professionals involved with your child:

Pediatrician	
Orthopedist	
Neurologist	
Neurosurgeon	
Physiatrist	
Cardiologist	
Ophthalmologist	
Psychiatrist	
Psychologist	
Chiropractor	
Gastroenterologist	
Pulmonologist	
Audiologist	
ENT	
Allergist	
Dentist	
Nutritionist	
Orthotist (Splints,/Brace Shop)	
Home Health Agency	
Medical Equipment Company	
Endocrinologist	
Geneticist	
School Therapist	
Primary Service Coordinator	
Other:	

Please check any of the following that are currently involved with your child:

- Commission for Children with Special Healthcare Needs
- First Steps Indiana Commission for Children VIPS LDOS
- Green Hill Aquatherapy Kosair Neurology Clinic
- Weisskopf Child Evaluation Center C.O.O.L. Home of the Innocents
- Associates in Pediatric Therapy Cincinnati Childrens KORT

2. Medications: Please list all medications, dosage, and reason for medication:

Medication:	Dosage:	For:

What medication side effects are noticed and at what time of day? (if applicable)

3. Planned or scheduled appointments/tests/procedures:

Please list any appointments, tests, &/or medical procedures that are scheduled (when/where) _____

4. Current therapies:

Does your child receive the following therapies through the school system? (If yes, please provide frequency and name of therapist)

Speech Therapy yes no _____

Occupational Therapy yes no _____

Physical Therapy yes no _____

Does your child **currently** receive therapy services (**not at school**)? (Provide location, frequency and name of therapist)

Speech Therapy yes no _____

Occupational Therapy yes no _____

Physical Therapy yes no _____

5. Relevant family/home circumstances or routines:

Please list all the people living in your home (include age and relationship to child):

What language is used primarily in your home: _____

What is the preferred language for printed instructions: _____

What type of transportation do you use: Private Public Do you have or need a lift? _____

Home Environment: Stairs Indoors Outdoors How many? _____

Railing(s)? _____ Ramp Living quarters on how many levels? _____

What equipment do you have in your home for your child?

Wheelchair Stander Gait trainer Walker Braces for legs/feet

Splints for hands bath seat special seating: _____

Other: _____

6. School/Education: My child **currently** attends: (please enter location & grade if applicable):

- Day Care _____
- Preschool _____
- Kindergarten _____
- Elementary School/Grade _____
- Middle School/Grade _____
- HighSchool/Grade _____