

Date: _____ By: _____

Patient First Name: _____ Last Name: _____ DOB: _____

Primary DX: _____ Secondary DX: _____

Shoe size w/o braces: _____ Shoe size w/ braces: _____

Height: _____ Weight: _____ Shirt Size: _____ Pant size: _____

Parent/Guardians name: _____

Telephone: _____ Cell: _____

Home Address: _____

City: _____ State: _____ Zip: _____

E-mail address: _____

Session Preferred: Date _____ AM/PM? _____

Seizures: Are they controlled and how? _____ Seizure type: _____

Dates of past 2-3 seizures: _____

Hip problems (Subluxation/dislocation): _____ Date of last x-ray: _____

Bone density issues: _____ Scoliosis (%) (correction) _____

Heart or blood pressure issues: _____

Kidney/liver issues: _____ G-tube or shunt: _____

Recent surgeries or fractures (dates & cause) : _____

Medications/ for: _____

Current Therapies: PT _____ OT _____ Speech _____ Other _____

Attends school: _____ Grade: _____

Weight bearing/standing: _____

Ambulation: _____

Wheelchair/walker/crutches/walking independently? : _____

Communication: _____ Sitting: _____

Crawling: _____ Feeding: _____

Additional information:

How did they hear about us? _____