EBS CHILDREN'S INSTITUTE
Research • Training • Treatment

Physical Therapy Intake Form

Child's Name: _____ DOB: _____

Current Diagnoses: _____

What are your primary areas of concern?

_____
_____
_____
_____

What are your goals for therapy?

_____
_____
_____
_____

Please list any medical precautions:

_____
_____
_____
_____

Please list any significant illness, hospitalization, or surgery:

_____
_____
_____
_____

Please check all that apply, and describe your concerns about your child.

Gross Motor:

- ☐ Difficulty with jumping, skipping, running, hopping
- ☐ Difficulty kicking a ball
- ☐ Difficulty throwing and/or catching a ball
- ☐ Appears weaker than peers, fatigues easily
- ☐ Avoids or has difficulty playing on playground equipment
- ☐ Appears stiff or awkward during movement
- ☐ Clumsy, decreased awareness of body in space, bumps into objects and people
- ☐ Difficulty coordinating two sides of the body
- ☐ Poor posture, frequently leans into things
- ☐ Awkward gait, unsteady walking, toe walking, drags feet
- ☐ Difficulty negotiating the stairs

Concerns:

_____

_____

Fine Motor:

- ☐ Difficulty with drawing, coloring, tracing
- ☐ Avoids drawing, coloring, tracing and/or writing
- ☐ Problem holding writing tools (grasp too lose, tight or awkward)
- ☐ Writing is too dark, light, large, or small
- ☐ Switches hands frequently, appears to have no dominant hand
- ☐ Slow in completing tabletop tasks
- ☐ Poor posture while sitting in a chair, leans into desk, fidgets
- ☐ Difficulty using classroom tools such as scissors and glue
- ☐ Shifts body rather than rotating across midline

Concerns:

_____

_____

Does your child have trouble keeping up with peers during physical play? ☐ Yes ☐ No

If yes, please explain: _____

Does your child participate in any extra-curricular activities? ☐ Yes ☐ No

If yes, please list all activities: _____