Beckman and Associates
Physical Therapy Intake Sheet Form

Name: _____ Date of Birth: _____

Parent / Legal Guardian Names: _____

Reason for Referral: _____

Known Medical Diagnosis: _____

Past Medical History:

_____

_____

_____

Any events at birth or pregnancy? _____

Past Surgeries? _____

Medical Specialist / Other Therapists? _____

Medications? _____ Allergies? _____

Caregivers concern: _____

Goals you would like for your child to achieve in the future:

_____

Age of Milestones:

_____ Rolling _____ Crawling on all fours _____ Sitting up independently

_____ Standing up _____ Walking

Does your child fall frequently? ☐ YES ☐ NO _____

Does he become frustrated easily when he is unable to complete a task? ☐ YES ☐ NO _____

Is she/he scared/avoids uneven surfaces? ☐ YES ☐ NO _____

Is she/he scared/avoids high places? ☐ YES ☐ NO _____

Is she/he regardless of his own safety? ☐ YES ☐ NO _____

Does your child have a hand/foot preference? ☐ YES ☐ NO _____

Does your child have any visual or hearing difficulties? ☐ YES ☐ NO _____

Does your child wear Orthotics or braces? ☐ YES ☐ NO _____

Signature: _____(sign your name) **Date:** _____

If you have any questions or concerns, please do not hesitate to voice them at any time.