Back in Balance
A centre for wellbeing

Pediatric Physiotherapy Patient Information and Health History

The purpose of collecting this information is important in your physiotherapy evaluation process. This information is kept confidential and is a requirement by the College of Physiotherapists of Ontario who may inspect these records as part of their regulatory activities in the public interest.

Child's full name:___________________ Date of birth:_________________________

Address: _______________________________ Parents: ____________________________

Phone: _______________________________ Email: _____________________________

Diagnosis: ____

Who may we thank for referring you?:____

Pediatrician/ Family Doctor:____

Brothers and Sisters (ages):____

May we contact your healthcare provider(s) to update them on your care? Yes No

Commitment to Physiotherapy

So often I have heard that clients do not feel like they have enough time with their healthcare provider and I feel it is important to provide clients with a different level of commitment to their health. As such, my mission is to provide evidence-based, holistic, one-on-one physiotherapy services to my clients. To maintain the integrity of this type of services, I am required to set aside significant time for your assessment, treatment and care. However, without adequate notice of cancellation it is difficult to fill appointment times for other clients. I understand that sometime life brings unexpected events and you may need to cancel your appointment. However, clients who do not provide 24 hours notice without a legitimate excuse will be charged the full physiotherapy fee for their session. This charge is not covered by insurance and will be the responsibility of the client to pay.

By signing below, I acknowledge that any appointment needing to be cancelled must be done 24 hours prior to the appointment time.

____ ______________________________

Patient/ Guardian Signature Date (DD/MM/YY)

Pediatric Physiotherapy

Pediatric assessment and treatment will include hands on therapy and a combination of manual therapy, k-taping, exercise program, vestibular and visual screening and treatment and/or education. I, the undersigned patient/guardian, give my consent to undergo such assessment and treatment and know that I can withdraw my consent at any time and that I am free to bring an additional person to any treatment sessions to act as my advocate.

Please initial to confirm that you have read our office fees and policies _________________

Date of Initial Health History : _____________________

Update 1: ____________ Update 2:_____________Update 3: _____________ Update 4: _____________

Is there a family history of the following?

Cognitive difficulties	Epilepsy	Blindness
Syndromes	Cleft Lip/Palate	Cerebral Palsy
Stuttering	Mental Illness	Speech Difficulties
Language delay	Dyslexia	Attention

Prenatal and Birth History

Mother's general health during pregnancy:_______________________________________

Length of pregnancy: ____________   Your child's weight at birth: _______________

Were any medications taken during pregnancy?__________________________________

Were there any complications or pre/post natal concerns?

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Medical History

Has your child had any surgeries? If yes, what type and

when?____

_____

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Describe any major accidents or hospitalizations:

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Is your child taking any medications? If yes, please identify. _________________________________

Have there been any negative effects to medications? If yes, please identify. ___________________

Has your child suffered from any of the following conditions (please include approximate age)?

Allergies	Asthma	Chicken Pox
Chronic Colds	Convulsions	Croup
Dizziness	Draining Ear	Ear Infections
Encephalitis	German Measles	Headaches
High Fever	Influenza	Mastoiditis
Measles	Meningitis	Mumps
Pneumonia	Seizures	Sinusitis
Tinnitus	Tonsillitis	Cardiac problem
Chronic Upper Respiratory	Infections	Other

Developmental History

Provide the approximate age at which your child began to do the following:

Support head	Roll: One side	Both side
Reach & grasp	Sit alone	Crawl
Stand alone	Walk alone	Feed self
Dress self	Use toilet	

Have any other specialists seen your child? If yes, indicate the type of specialist, when the child was seen, and the specialist's conclusions/suggestions?

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Play and Social Development

Which of the following does your child like to engage in:

Putting toys in mouth	banging toys	throwing toys
Pushing toys	spinning toys	pretend play
Games with rules	rough play	crafts
Building toys	outdoor play	looking at books

How long does you child stay with one activity?

What are your child's preferred activities?

How does your child play with other children?

Do you have any discipline problems with your child? If yes, please describe.

Educational History

Has your child started school or nursery school?
If yes, what grade/class?
School/Nursery School's name:
Teacher's name:
Has the teacher/school brought any concerns to your attention?

Please provide us with any other information that you can think of that would be helpful in the assessment or remediation of your child's difficulties:

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Person providing information:
Date: