



Physical Therapy Intake Form

What led you to seek Physical Therapy services for your child?

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

Gross Motor:

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

Concerns: _____

Fine Motor:

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

Concerns: _____

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

If yes, please explain: _____



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

If yes, please list all activities: _____
