RESILIENT CARE
PHYSICAL THERAPY
Quality hands that care for you.

57-18 Woodside Ave. Suite B102 Woodside, NY 11377
Tel: (719) 426-7900 Fax: (718) 426-7500

Today's Date _____

PEDIATRIC INTAKE FORM
(Please **PRINT** clearly)

*Please note that this form is for patient who is **under 18 years old ONLY.**

CHILD's INFORMATION		
Child's Last Name:	First:	Middle:
DOB:	Age:	Sex: ☐ Female ☐ Male

PARENT/GUARDIAN INFORMATION		
Parent/Guardian Name:		SS:
If you are a guardian, please specify your relationship to the above patient:		
Street Address:		Apt:
City:	State:	Zip Code:
Home Phone No:	Cell Phone No:	
E-mail Address:		

HEALTH CARE PROVIDER INFORMATION	
Referrring Doctor:	Tel. No:
Address:	

INSURANCE INFORMATION
Primary Insurance Carrier: Subscriber's Name: _____DOB: _____ Identification No: Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other
Secondary Insurance Carrier: Subscriber's Name: _____DOB: _____ Identification No: Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

How did you hear about us? (Please check) ☐ Doctor ☐ Hospital ☐ Insurance ☐ Family ☐ Friend
☐ Flyer ☐ Website ☐ Street Sign ☐ Yellow Pages ☐ Close to Home/Work ☐ Other

MEDICAL HISTORY

Please describe your child's signs and symptoms, complaints or difficulties for which you are seeking Physical Therapy:

_____

_____

Has your child had any special test performed for this condition? (Please check)

☐ X-Ray ☐ MRI ☐ CT Scan ☐ Other (Please specify):_____

If yes, please list the results:

_____

_____

Has your child had any operations? Please list the procedure(s) and the year(s):

_____

_____

Has your child previously received physical therapy treatments for this condition? ☐ Yes ☐ No

If yes, how many visits? _____

Allergy (Please specify):_____

Has your child had any history of OR currently experiencing any of the following conditions?

☐ Asthma	☐ Cerebral Palsy	☐ Hepatitis
☐ Cancer	☐ Down Syndrome	Type A ☐ B ☐ C ☐
☐ High Blood Pressure	☐ Osteoarthritis	☐ Diabetes
☐ Low Blood Pressure	☐ Rheumatoid Arthritis	Type I ☐ II ☐
☐ Heart Murmur	☐ Hip Dysplasia	☐ Stroke
☐ Seizures	☐ Scoliosis	At what age? _____

☐ Other (Please specify): _____

Is your child currently taking any medication? ☐ Yes ☐ No
If yes, please specify: _____

To the best of my knowledge, all of the above answers are true and correct. If ever there will be any changes in my child's health, or if his/her medications change, I will inform the treating physical therapist at the next appointment.

Signature of Parent/Guardian: _____ Date:_____

Signature of Physical Therapist: _____ Date:_____