



More Than Words... Therapy Services, LLC
215-A Dunbar Cave Rd | Clarksville, TN 37043
Telephone: 931.542.2739 | Fax: 931.233.9970
Website: www.MoreThanWordsLLC.com
Facebook: MoreThanWordsTherapy

Physical Therapy Intake

New Client Information

Date: _____
Patient: _____ DOB: _____
Age: _____ Gender: M/F

Birth History

Born at _____ weeks gestation. Birth weight: _____
Born vaginal or cesarean delivery? _____
Did your child require NICU care? Y/N Please describe: _____

Please describe any significant birth, medical, or surgical history: _____

Medications: _____

Allergies: _____

Precautions: _____

Please indicate whether or not your child has received any of the following therapies in the past year:

THErapy	DATE OF LAST EVALUATION	THErapy PROVIDER
Speech/language therapy		
Occupational therapy		



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Physical therapy		
Nurtition/feeding therapy		
Psychological/behavioral		

Has your child received any of the above therapies in the school system?

Please list: _____

Diagnoses (check all that apply):

- Autism
- Asperger's syndrome
- Cerebral palsy
- Hypotonia (low tone)
- ADD/ADHD (Attention Deficit Disorder)
- Cognitive delay
- Down syndrome
- Pervasive Developmental Disorder
- Learning disability
- Genetic disorder
- Sensory processing disorder or sensory integration dysfunction
- Anxiety or mood disorder

specify: _____

- Emotional disorder
specify: _____

- Other
Specify _____

Parental Concerns

What are the presenting problems for your child? Please rank them according to level of concern.

RANK	CATEGORY	PARENTAL CONCERNS	AGE BEGAN
	Sensory		



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	Motor (gross/fine)		
	Activities of Daily Living (eating, Dressing, etc)		
	Play		
	Behavior		
	Academic		
	Language		
	Other		

Gross and Fine Motor Skills

(Please check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Crawls independently | <input type="checkbox"/> Appears stiff, awkward, or clumsy |
| <input type="checkbox"/> Walks independently | <input type="checkbox"/> Difficulty with scissors |
| <input type="checkbox"/> Runs independently | <input type="checkbox"/> Difficulty learning new tasks |
| <input type="checkbox"/> Jumps independently | <input type="checkbox"/> Difficulty throwing a ball |
| <input type="checkbox"/> Seems weaker or tires more easily than | <input type="checkbox"/> Difficulty catching a ball |
| <input type="checkbox"/> Dislikes coloring or paper/pencil | <input type="checkbox"/> Difficulty kicking a ball |
| | <input type="checkbox"/> Difficulty/dislikes being on swings |



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- | | |
|--|---|
| <input type="checkbox"/> tasks | <input type="checkbox"/> Able to go up stairs |
| <input type="checkbox"/> Able to ride a bike/tricycle | <input type="checkbox"/> Able to go down stairs |
| <input type="checkbox"/> Dislikes/gets frustrated with puzzles | <input type="checkbox"/> Walks on toes |
| <input type="checkbox"/> Rocks back/forth when stressed | <input type="checkbox"/> Trips/falls frequently |
| | <input type="checkbox"/> Seeks twirling or spinning |

Sports/activities/toys your child enjoys: _____

Comments/concerns: _____

Developmental Milestones

Please indicate at what age your child was able to complete the following:

Roll over: _____

Sit independently: _____

Crawl: _____

Walk: _____

Did your child dislike tummy time? _____

Did your child spend time in baby walkers (activity discs) or jumpers? _____

If so, how long each day? _____

Auditory and Language

(Please check all that apply)

- Has diagnosed hearing loss
- Stammers or stutters
- Certain noises scare him/her
- Speaks in incomplete sentences
- Has or has had repeated ear infections
- Fails to listen or pay attention to what is said to him/her
- Is difficult to understand



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- History of delayed speech development
- Talks constantly

If your child does not currently verbalize, how does she/he communicate? _____

Social/Emotional/Behavioral Skills

(Please check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Does not accept change in routine easily | <input type="checkbox"/> Is generally disorganized |
| <input type="checkbox"/> Seems to do things the hard way | <input type="checkbox"/> Frequently breaks toys or plays rough |
| <input type="checkbox"/> Becomes easily frustrated | <input type="checkbox"/> Does not finish what is started |
| <input type="checkbox"/> Changes activities frequently | <input type="checkbox"/> Acts without thinking |
| <input type="checkbox"/> Is impulsive or accident prone | <input type="checkbox"/> Runs rather than walks |
| <input type="checkbox"/> Hums or taps fingers often | <input type="checkbox"/> Does like loud or busy places |
| <input type="checkbox"/> Takes a long time to settle down | <input type="checkbox"/> Fidgets or squirms |
| <input type="checkbox"/> Tends to withdraw from groups | <input type="checkbox"/> Cannot tell right from wrong |
| <input type="checkbox"/> Is overly concerned with performance | <input type="checkbox"/> Forgets social expectations |
| <input type="checkbox"/> Has poor self-image | <input type="checkbox"/> Is insensitive to others' feelings |
| <input type="checkbox"/> Has a temper and will explode at the slightest irritant | <input type="checkbox"/> Demonstrates inappropriate sexual Behavior (touches self or others) |

Self-Care

(Mark the appropriate box to indicate your child's level of development:

Level of Independence	Independent	With a little help (up to 25%)	With some help (up to 50%)	With a lot of help (up to 75%)	Total help needed (100%)
HYGIENE					



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Hand washing					
Tooth brushing					
Showering					
TOILETING					
Wiping					
Feminine hygiene					
DRESSING					
Clothes on					
Clothes off					
Shoes on					
Shoes off					
Ties shoes					
FEEDING					
Bottle					
Sippy cup					
Open cup					
Utensils					
Prefers hands					
Cuts with knife and fork					