ONE POINT
PHYSICAL THERAPY

867 Greenwood Ave NE
Atlanta, GA 30306
404-600-4627

GENERAL HISTORY INFORMATION

Child's Name:______________________________________ DOB:_____________________ Sex: ☐M ☐F

Parent(s) Name: ____________________________________ Parent SSN: __________________________

Phone: ____ Work phone:_________________________

Address:___________________________________ City:_________________ State:_____ Zip:_________

Email Address:____

Would you like appointment reminders? ☐Yes ☐No If Yes; ☐Text ☐Email

How did you hear about us? ☐Doctor ☐Friend ☐Website ☐Attorney ☐Other____________________

PEDIATRICIAN INFORMATION

Child's Pediatrician:____ Phone:______________________

Did your Pediatrician refer you? ☐Yes ☐No

If no, name of referring provider:_______________________________ Phone:______________________

Reason for Referral:_________________________ Child's age when problems first noticed:___________

Other physicians your child sees:_______________________________ Specialty:____________________

EMERGENCY CONTACT INFORMATION

Name:____________________________________ Relationship:__________________________________

Home/Cell Phone:___________________________ Work Phone: _________________________________

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INSURANCE INFORMATION

Insurance Company Name:______________________________ DOB of Guarantor:__________________

Insured Party: ☐ Self ☐ Spouse ☐ Parent ☐ Employer ☐ Other

Secondary Insurance information (if applicable)

Secondary Insurance Name:______________________________ Phone Number: ____________________

PATIENT HISTORY

When did you first become concerned about your child's development: ___________________________

Has your child received occupational, physical, or speech therapy in the past or is he/she currently receiving any of these services:____

____

Please indicate at what age each major milestone was reached (if applicable):

Sitting _______ Crawling__________ Walking_____________ First word___________

School History of Child (if applicable) (Name of school/daycare, grade, etc): ________________________

Does your child have a current IEP (individualized education program): ☐ Yes ☐ No

Does your child have siblings, please list names and ages: _______________________________________

MEDICAL HISTORY

Did the child's mother have any illnesses or complications during pregnancy or delivery? Please describe:

____

Was your child premature: ☐Yes or ☐No

Born at how many weeks gestation?___________ Birth Weight____________

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Did your child require any medical procedures before, during, or after birth? Please describe: _________

____

FEEDING

Did/does your child have any feeding problems as an infant? Please describe: ______________________

____

Was/is your child bottle fed or breast fed and for how long: ____________________________________

Does your child have any colic or reflux issues: ____

HEARING

Has your child had any ear infections? (Please list number if known): ____________________________

Has your child had their hearing tested? What were the results: _________________________________

VISION

Does your child wear glasses or have any visual concerns:_______________________________________

ILLNESS

Does your child take any medications? Please list: ____

Does your child have any allergies? Please list:____

Please describe illnesses, medical issues, or hospitalizations that your child has had and when they occurred: ____

____

Please list current concerns/expectations/goals for your child at this time:____

____