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

Reason for today's visit: _____

When did the problem begin? _____

Date of Surgery (if applicable): _____

Has your child been treated for this problem before? ☐ Yes ☐ No

If yes, when and by whom? _____

Has your child received any diagnostic imaging related to the problem? _____

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

Does your child have any difficulty with coordination (Running, jumping, climbing, hopping etc?)_____

_____

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

School History of Child (if applicable) (Name of school/daycare, grade, etc.)_____

_____

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MEDICAL HISTORY

Did your child have any difficulties during/after birth? _____

Please list any prior surgeries with approximate dates:_____

Does your child take any medications? Please list: _____

Does your child have any allergies? Please list:_____

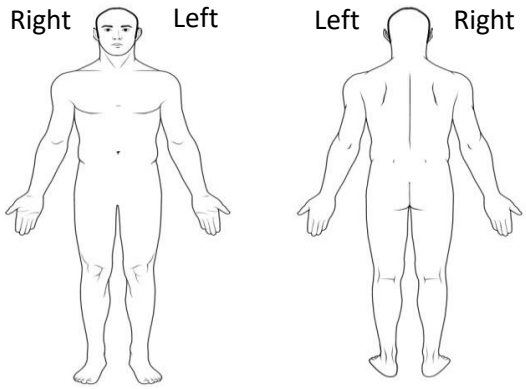
Please describe illnesses, medical issues, or hospitalizations that your child has had and when they occurred: _____

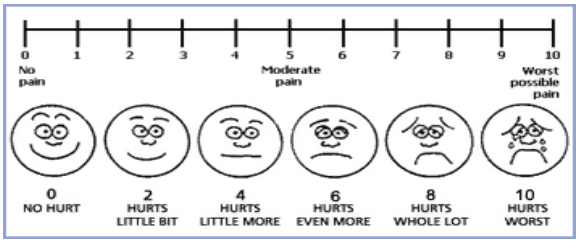
_____

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

_____

Please indicate on diagram below where you are currently experiencing pain.





Please rate your level of pain from 0-10

Current pain level: _____

Pain at worst: _____

Pain at best: _____

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