JEAN ANNE ZOLLARS, PT, DPT, MA
PHYSICAL THERAPIST

INTAKE INFORMATION (infants and children)

CLIENT INFORMATION

Client Name:_____ Date:_____
Mother's Name:_____ Father/Partner's Name: _____
Address: _____ Home Phone: _____
City, State, Zip_____ Office Phone: _____
Cell Phone: _____

Age:_____ Date of Birth:_____
Weight _____ Sex: M ( ) F ( ) Referred by:_____
Doctor's Name_____ Phone # _____
Has the child ever had chiropractic, physical therapy, massage therapy or alternative health care before? For what problem? _____
_____

SYMPTOMS & COMPLAINTS

What concerns have brought your child here? _____
_____
_____
Please list the child's major complaints, symptoms - be as specific as you can: _____
_____
_____
How do you believe the problem began? _____
_____
What is the child's official diagnosis? _____

MEDICAL HISTORY

Please indicate the child's present medical status: illnesses, diseases, fractures, allergies, digestive problems: _____
_____
_____

Any problems during pregnancy? – please be specific as you can _____
_____
_____
Please describe any problems at birth _____
_____
_____

Indicate your child's past history of health (and dates): illnesses, diseases, fractures, accidents, traumas (All trauma in the past – accidents, falls & injuries are important):_____

_____

_____

List operations your child has undergone and dates: _____

_____

_____

List all medications (including vitamins, herbs or over the counter drugs) your child is presently taking _____

_____

_____

List any diagnostic tests (X-ray, MRI, etc.) your child had and the results _____

_____

FUNCTION

List your child's present hobbies or activities _____

_____

_____

Please list activities that are difficult for your child _____

_____

_____

_____

CLIENT AGREEMENT AND RELEASE FROM LIABILITY

I,_____ (parent's name) agree to the following during and after the course of my child's therapy. (Initials)

1) At any time during a session, I have the right to stop the therapy if I feel uncomfortable. _____

2) I understand that the therapist is committed in assisting my child to heal him/herself in the shortest time possible. _____

3) I understand that there may be reactions to treatment, anticipated or unanticipated, and that it is my responsibility to discuss any symptoms of concern with the therapist. _____

4) If I need to cancel an appointment, I will do so 24 hours prior to the appointment. I understand that a late fee will be charged if I cancel less than 24 hours prior to the appointment. _____