GUIDED PATH
THERAPIES
LISTENING. LEARNING. GROWING.

Who is completing this form today? _____

Relationship to Person being evaluated? _____

Child's Name (First) _____ (MI) _____(Last)_____

DOB: _____Age: _____ Gender: _____ Male _____ Female _____ Neutral

Please list all known allergies (food, medications, seasonal, etc)_____

_____

Who does the child currently live with? _____

Describe this child's present state of health: _____

_____

List any diagnosis (Ex. Cerebral Palsy, Autism, Down's Syndrome, etc.):_____

_____

_____

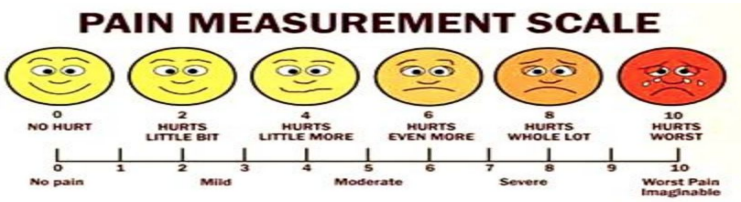
List current medications (Name, Dose, & reason for taking): _____

_____

_____

Has your child experienced any of the following (if yes please explain below):

____ Allergy problems	____ Hearing problems	____ Nightmares
____ Seizures	____ Poisoning	____ Unusual Behaviors
____ Loss of consciousness	____ Operations	____ Physical/sexual abuse
____ Earaches	____ Vision problems	____ Going limp or falling
____ Extreme fever	____ Head Injury	____ Fainting spells
____ Convulsions	____ Swallowing difficulties	____ Temper tantrums



Have there been any complaints of pain/discomfort in the last 4 weeks? What about today? If so, please rate the pain on the scale.

Please explain: Note any diseases, surgeries, injuries, hospitalizations or other significant medical history

_____

_____

_____

Has anyone in the child's immediate family (parents, brothers, sisters), EVER been diagnosed with any of the following conditions?

____ Cancer
____ Heart Problems
____ HIgh Blood Pressure
____ Diabetes
____ Stroke
____ Depression
____ Tuberculosis
____ Thyroid Problems
____ Blood Clots
____ Mental Health Issue

Gross Motor Development

At what age did your child sit alone? _____ Walk alone? _____

Does your child currently have any adaptive equipment (such as AFO's, wheelchair, booster chair or stander)? If so, which items? _____

List any other gross motor/activity concerns you might have about your child:_____

_____

What activities does your child like to do in their free time? _____

_____

Does your child have difficulty with any of the following tasks?

_____ Sitting up without support
_____ Crawling on the floor
_____ Climbing up & down stairs
_____ Rolling a ball back & forth
_____ Getting in/out of bed or chair
_____ Catching a ball
_____ Pushing his/her wheelchair
_____ Throwing a ball
_____ Moving his/her walker
_____ Skipping or running
_____ Riding a bicycle
_____ Falls a lot
_____ Falls when running
_____ Doesn't like to jump
_____ Gets tired easily
_____ Dislikes physical exercise
_____ Seems uncoordinated compared to other children
_____ Climbing on/off playground equipment
_____ Walks differently than other children

Gastrointestinal	**Urogenital**
Swallowing Difficulties? _____	Any recent changes in bowel/bladder function? _____
Regular water drinker? How much water/day? _____	Urine color: _____ Flow changes?_____
Any food intolerance? _____	Incontinence? _____
Potty-trained? _____	Regular periods/menstruation?
Constipation/Diarrhea? _____	_____
Melena? _____	Sexually active? _____
Nausea/Vomiting? _____	Any discharge? Color/odor present? _____
Dizzy/Lightheadedness?_____	

Mental Health	Cardiovascular
During the past month, have you often been bothered by feeling down, depressed or hopeless? During the past month, have you often been bothered by little interest or pleasure in doing things? Is this something with which you would like help?	Current BP: _____ HR: _____bpm Quality of pulse_____ Current Height: _____ Current Weight: _____ Please circle one: Over the last 6 months, the current weight has a) increased b) decreased c) stayed the same

PHYSICAL ACTIVITY READINESS QUESTIONNAIRE (PAR-Q)	
Has your doctor ever said that you have a heart condition and that you should only perform physical activity recommended by a doctor?	Do you feel pain in your chest when you perform physical activity?
In the past month, have you had chest pain when you were not performing any physical activity?	Do you lose your balance because of dizziness or do you ever lose consciousness?
Do you have a bone or joint problem that could be made worse by a change in your physical activity?	Is your doctor currently prescribing any medication for your blood pressure or for a heart condition?
Do you know of any other reason why you should not engage in physical activity?	**If you have answered "Yes" to one or more of the above questions, consult your physician before engaging in physical activity. Tell your physician which questions you answered "Yes" to. After a medical evaluation, seek advice from your physician on what type of activity is suitable for your current condition.**

Thank you so much for completing this information. This will help us be more prepared for our first meeting. Someone from our team will be reaching out to you soon to set up an appointment. If you should have any questions, please feel free to reach out to our office with any questions.

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