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PHYSIOTHERAPY

DEVELOPMENT HISTORY

Child's Name: _____

Date of Birth: _____ Place of Birth: _____

Prepared By: _____Today's Date: _____

Address: _____

Telephone Home_____ Email: _____

Mobile (Mother):_____Mobile (Father): _____

How did you hear about this treatment? _____

Mother – Full Name: _____

Date of Birth: _____ Occupation: _____

Father – Full Name: _____

Date of Birth: _____ Occupation: _____

Child's Brothers and Sisters:

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Who has overall responsibility for the child? _____

School or Kinder your child attends _____

School Contact Person's details:

_____

_____

Mobile 0433 298 974 **Fax** 03 8669 4104 **Email** contactus@oceanphysio.com.au **Mail** PO Box 267, Balnarring VIC 3926 **oceanphysio.com.au**
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Please list below the names and addresses of all the people who may have relevant information about your child - for example: Paediatrician, Physiotherapists, Allied Health professionals, Specialists, GPs etc.

Name	Clinic	Email	Phone

Does your child have a diagnosis? _____

_____

_____

Date of Diagnosis? _____

If your child does not have a formal diagnosis, what are your concerns?

_____

_____

_____

What are the key movement problems you would like us to work on with your child?

_____

_____

_____

_____

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Please list any surgical or medical intervention that your child has had e.g. Botox, Muscle lengthening

Procedure: _____Date: _____ Location: _____

Procedure: _____Date: _____ Location: _____

Procedure: _____Date: _____ Location: _____

Procedure: _____Date: _____ Location: _____

Does your child have a Scoliosis? _____

If so, date of last X-Ray _____ Cobb Angle Measurement _____

Does your child have hip subluxtion? Yes / NO (please circle)

If yes, what is the migration % _____ Date of last ultrasound: _____

What *CAN* he or she do which makes you particularly proud of him or her?

_____

_____

_____

SCHOOLING

Does your child go to school? _____

If yes, which school? (please specify whether mainstream or special school)_____

If mainstream, is he or she in a class at his/her peer level? _____

Does your child have an Integration aide? _____

Does your child require any special equipment or furniture? E.g. Wheelchair, walker, AFO's, speech devices?

_____

_____

_____

_____

_____

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For the next questions, please use the right-hand column to describe your child's current level of function

VISION	DESCRIPTION
Does your child wear glasses?	Type:
Describe your Childs vision	
HEARING	
Does your child have a hearing deficit?	
Please describe your Childs hearing	
Did your child have grommets?	
Is your child sensitive to loud noises?	
COMMUNICATION	
Is your child able to talk? If not, how do you communicate with your child?	
Can your child follow instructions?	
Describe the base way for us to communication with your child?	
TACTILITY	
Does your child react to being touched or handled e.g. defensive?	
Is your child sensitive to different textures? If so, please describe	
Does your child seek out things to touch?	
Does your child have any difficulties with sensation? Feeling?	

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MOBILITY	
At what age, if at all, did your child begin to move his or her arms and legs?	
Is there any stiffness in his or her limbs?	
At what age, if at all, did your child learn to roll over?	
At what age, if at all, did your child begin to creep?	
At what age, if at all, did your child sit up by themselves?	
At what age, if at all, did your child begin to crawl on hands and knees?	
At what age, if at all, did your child begin to stand against furniture?	
At what age, if at all, did your child stand independently?	
At what age, if at all, did your child begin to walk?	
At what age, if at all, did your child begin to run?	
Does your child have any further mobility skills, such as skipping, hopping, kicking a ball etc.?	
FINE MOTOR	
Can your child use two hands to pick up a teddy?	
Can you child dress themselves? Please describe the assistance they need	
Can your child pick up tiny objects with finger and thumb	
Can your child use a pencil and write?	
SOCIAL	
Describe your child's personality	
Is your child toilet trained? What assistance do they need?	
Does your child sleep through the night?	

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FEEDING	
Can your child feed themselves? What sort of assistance do they need?	
Describe their current diet?	
Childs current weight (kg)	
Any difficulties swallowing / drinking liquids?	

SEIZURES	
Is your child epileptic?	
Describe the frequency, intensity and duration of their seizures	
What medication do they take for seizures?	
What do you do when they have a seizure?	
MEDICATION	
Please list ALL medications your child is taking regularly and what each is for	
OTHER	
Does your child perspire with activity?	
Are your child's hands and feet generally warm or cold?	
Any issues with constipation or diahorrea?	
What does your child do after school and on weekends? (extracurricular activities)	

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CLIENT MOTIVATION

When doing any sort of therapy there is always an element of motivation required on the child's behalf. As a therapist it is hard to identify under what circumstances a child will perform their best the first time you meet them. This is however the crucial time when connections and relationships and trust are formed. So, we ask guidance from the parents as to what motivates their child the best.

How do you encourage your child to move or do tasks?

What sort of games does your child like?

Do you use positive re-enforcement to motivate them or discipline?

To get the most from your child what other advice would you have for us?

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Thank you for completing this history form. It will assist us to perform a thorough assessment and provide the most appropriate program for your child. To return this to us, you can:

- Scan and email to contactus@oceanphysio.com.au
- Fax to 03 86694104, marked attention Katie Cleary
- Post to PO Box 267, Balnarring, VIC 3927

If you have any questions about it, please contact our Senior Physiotherapist, Katie Cleary on:

M: 0433298974
E: katie@oceanphysio.com.au