Jones
THERAPY SERVICES
615-614-8833 jonestherapyservices.com

Child's Full Name: _____ Date of Birth: _____/_____/_____

Physical Therapy Information

What are your primary concerns with your child's motor skills? _____

_____

_____

Please describe how much help, if any, your child requires with self-care skills (dressing, bathing, feeding)? _____

_____

_____

Please describe your child's walking and/or balance issues or concerns, if any? _____

_____

Has your child developed a hand preference? Yes No If yes, Right Left

Does your child have a foot preference? Yes No If yes, Right Left

Does your child have any orthotics or adaptive equipment? Yes No If yes, please describe _____

_____

What do you see as your child's most difficult problem in the home? _____

_____

What do you see as your child's most difficult problem in school? _____

_____

Additional Comments or Concerns

_____

_____

_____