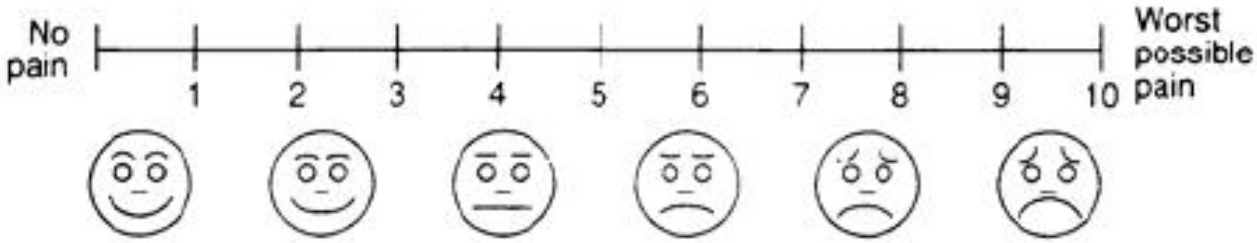
Torticollis Intake Questionnaire

PLEASE BRING THIS WITH YOU FOR YOUR CHILD'S EVALUATION

Person Completing Questionnaire:	**Relationship to Child:**		
Child's Name: (First) (MI) (Last)			
Date of Birth:	**Age:**		
Male **Female**			
Address: (Street) (Apt)	City	State	Zip Code
Phone Number:			

Diagnosis:	
Allergies (Drug and food)**:**	**Medications** (Prescription and non-prescription)**:**

Referring Provider:



What are your primary concerns/Why did you bring your child in for an evaluation?

Family History:	
Caregiver #1 Name: **Age:**	**Caregiver #2 Name:** **Age:**
Relationship to Child:	**Relationship to Child:**
Caregiver preferred method of learning: Listening Reading Pictures Demonstration Other:_____	**Caregiver preferred method of learning:** Listening Reading Pictures Demonstration Other:_____
Biological Adopted Step-child Foster Other:_____	Biological Adopted Step-child Foster Other:_____
*** Language(s) Spoken in the Home:**	**Primary Language of Caregiver:**

CONTACT INFORMATION:

The following are the best contact numbers for me to most reliably be reached during business hours:

_____ _____

(Phone #1) (Phone #2)

EMERGENCY CONTACT: In case of an emergency, I hereby authorize only the following persons to pick up my child:

Name_____Relationship_____Phone_____

Name_____Relationship_____Phone_____

Health Care Providers
Primary Care Physician/Office: _____

Specialists: (check all that apply)	**Name of Specialist(s)**	**Phone Number**	**Date(s) of Service**
Neurologist			
Orthopedist			
ENT (Ear, Nose, and Throat)			
Optometrist/ophthalmologist			
Cardiologist			
GI (Gastroenterologist)			
Other:_____			

When did you first notice this?

Birth History:

Full Term **Prematurity at _____ weeks gestation**

Single **Twin** **Triplet** **Other_____**

Labor: (check all that apply)

Vaginal	Forceps/Vacuum
C-section	Breech
Nuchal Cord	Other:_____

Feeding:

Nursing **Bottle** **Cup**

Sleeping Position:

Amount of Time Spent Prone (on the tummy) Per Day:

Spends Most of the Day (position):

Hearing:

Any concerns with child's hearing?

Yes No

Explain:

Vision:

Any concerns with child's vision?

Yes No

Explain:

Diagnostic Tests: (MRI, CT Scan, EEG,CUS, X-ray, etc.)		
Test	**Date**	**Results**

Current and Previous Therapies: (PT, OT, Chiropractor, Massage)		
Name of Provider(s)	**Clinic Name**	**Date(s) of Service**

History of Surgeries, Major Injuries, Illnesses, and Hospitalizations:
Date/Reason:
Date/Reason:
Date/Reason:
Date/Reason:
Date/Reason:

Relevant past/current medical conditions (heart, seizures, etc.)

I acknowledge that I have received a copy of the *Welcome to Pediatric Therapy Services* orientation packet.

Caregiver Signature:_____ Date:_____