Integrated Physical Therapy and Counseling

INFANT/PEDIATRIC INTAKE

Name:_____ Parents:_____

Address:_____

Phone #:_____ email:_____

Birthdate:_____ AGE:_____ Referred by_____

Pediatrician:_____

Concerns/Presenting Issues:

Nursing: Movement:

Eating: Attention:

Elimination: Sensory Integration:

Sleeping: Learning:

Social/Relational:

Family Dynamics:

Siblings: _____ Ages:_____

Parents: Home__ Work__ (days__; nights__) Occupation(s):_____

Support
System:_____

Pregnancy/Birth History:

Complications during pregnancy of fetus or Mom (include emotional issues):

Complications during birth (long labor, breech, cord wrapping, forceps/vacuum, other)?

C-section_____ Vaginal_____

Other comments:

INFANT/PEDIATRIC INTAKE (2)

Additional Information you would like to provide:

Goals/Desired Outcomes of treatment:

Consent to Treat: I have provided medical and emotional issues to the best of my ability. I recognize that IPT&C is a multidimensional treatment practice where physical therapy, Craniosacral Therapy and Mental Health Counseling are employed as needed to meet the physical and emotional needs of the patient or caretaker(s). I consent to this approach to treatment as recommended.

_____ _____

(sign name) **(Date)**

_____

Evaluation:

Recommendation:

_____ _____ _____

DJ Horn **Parent initials** **Date**