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EMPOWERING CHILDREN, FAMILIES AND OUR COMMUNITY.

Physical Therapy Questionnaire

Patient Name: _____

Date: _____

Younger than 18 months:

Older than 18 months:

| Please answer questions as they relate to your concern for seeking therapy services | Y | N | Skill achieved at what age? |
|---|---|---|-----------------------------|
| My child prefers to look or tips head to one side. | | | N/A |
| My child tolerates tummy time. | | | N/A |
| My child can hold their head up when on his/her tummy. | | | |
| My child can belly crawl forward. | | | |
| My child can crawl on his hands or knees. | | | |
| My child can sit independently. | | | |
| My child can pull to stand at a surface. | | | |
| My child can cruise at a surface. | | | |
| My child stands on his/her toes. | | | N/A |
| My child can walk independently. | | | |

| Please answer questions as they relate to your concern for seeking therapy services | Y | N | ADDITIONAL INFORMATION |
|---|---|---|--|
| My child has a history of or currently has pain (please circle all that apply and state for how long): | | | Neck Back Leg (R or L) Foot (R or L) Duration: |
| My child has difficulty going up/down stairs. | | | |
| My child trips or falls frequently. | | | |
| My child has difficulty with his/her balance. | | | |
| My child has difficulty with coordinating gross motor activities such as jumping jacks, skipping, or galloping. | | | |
| My child walks on his/her toes. | | | |
| My child has difficulty with ball skills (throwing, catching, kicking). | | | |
| Does your child have any orthotics (foot braces) currently, or a history of wearing orthotics? | | | If yes— Type: Age: |
| Does your child have any equipment (walkers, crutches, wheelchairs) currently, or have they used equipment in the past? | | | If yes-- Items: Age: |