



Physical Therapy (PT) Pre-Evaluation Questionnaire Toddler and Up

Child Name: _____ Date of Birth: _____

Caregiver Information

Caregiver's Name: _____

Role in Child's Life: Parent Grandparent Foster Parent Other _____

List your primary areas of concern: *Check all that apply*

- | | | |
|--|--|---|
| <input type="checkbox"/> Equipment | <input type="checkbox"/> Ataxic/Uncoordinated Movement | <input type="checkbox"/> Following Instructions |
| <input type="checkbox"/> Orthotics/ Braces | <input type="checkbox"/> Delayed Gross (Large) Skills | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Tight Muscles | <input type="checkbox"/> Frequent Falls/Clumsiness | |
| <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Play Skills on Playground | |
| <input type="checkbox"/> Torticollis | <input type="checkbox"/> Participation in Sports | |
| <input type="checkbox"/> Toe Walking | <input type="checkbox"/> Attention | |

Share what you want to accomplish by having a physical therapy evaluation:

Can your child follow one-step instructions to evaluate independent gross (large) motor skills? *Describe*

Therapy Specific Questions: *Check all that apply for your child's stage of development*

Gross (Large) Motor Skills

Does your child...	Yes	No	Does your child...	Yes	No
Sit independently			Walk independently		
Crawl			Run		
Stand at furniture			Walk up stairs		
Walk with assistance			Jump		



Child's Daily Environments

Home	Yes	No	Daycare or School	Yes	No
Steps into house			Climbing playground equipment		
2 or 3 stairs			Long hallways to classroom		
Stair case with 3 or more stairs			Curbs		
Tub			Ramps		
Ramps to door			Doors that open with door handles		

Equipment Specific Questions

Medical Equipment

<p>Does your child have any equipment needs? <input type="checkbox"/> Yes <input type="checkbox"/> NO <i>If yes, please explain.</i></p>
<p>Does your child need or use assistive devices such as wheelchair, walker, crutches, cane, etc.</p>
<p>Does your child need or use adaptive equipment such as stander, toilet seat, bath chair, etc.?</p>
<p>Does your child have braces or orthotics for feet or hands?</p>
<p>What is your child's primary means of mobility? Do they use rolling, crawling, scooting on bottom, walking, stroller or wheelchair to get around?</p>
<p>What are your child's greatest challenges when out in the community when visiting the park, the store, or family or friend's house etc.?</p>

Please provide as much information as possible. The physical therapist will review this information for your child's initial physical therapy evaluation.

UCP looks forward to serving you and your child!