



## 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><b>Does your child have any equipment needs? <input type="checkbox"/> Yes <input type="checkbox"/> NO <i>If yes, please explain.</i></b></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!**