Name _____ Date of Birth _____

Physical Therapy

Has your child ever had Physical Therapy? ☐ YES ☐ NO

Date:_____ Location:_____

What were they working on?_____

Does your child have problems with balance or coordination? ☐ YES ☐ NO

IF YES, please describe:_____

Do you have concerns regarding your child's movements or posture? ☐ YES ☐ NO

IF YES, please describe:_____

Which hand does your child use more frequently?_____

Has your child ever worn braces, orthotics, or shoe inserts? ☐ YES ☐ NO

IF YES, please describe:_____