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| Annual Physical Therapy Visit Template: Pediatric |

This form provides elements and suggested tests and measures for those elements to be included in an annual checkup for the pediatric population (birth-21 years). You can find links to specific tests mentioned in this document on [APTA’s Tests & Measures webpage](https://www.apta.org/patient-care/evidence-based-practice-resources/test-measures). The Annual Checkup is designed to take approximately 30 to 60 minutes depending on your child’s and family’s individual needs.

Name of Therapist/Caregiver Completing this Form: Click or tap here to enter text.

Name of Primary Care Practitioner: Click or tap here to enter text.

Date of Examination: Click or tap to enter a date.

# ****Personal Health Profile****

## Demographics and Family Information:

Name: Click or tap here to enter text.

Date of Birth: Click or tap to enter a date.

Gender: [ ]  Female [ ]  Male [ ]  Other Click or tap here to enter text.

Support/caregiver’s preferred contact method ([ ]  phone [ ]  text [ ]  email)? Click or tap here to enter text.

Medical insurance: [ ]  adequate [ ]  inadequate [ ]  other Click or tap here to enter text.

## Ethnicity:

[ ]  Hispanic or Latino [ ]  Not Hispanic or Latino

## Race:

[ ]  American Indian or Alaska Native

[ ]  Black or African American

[ ]  Chinese, Filipino, Asian Indian, Vietnamese, Korean, Japanese, or Other Asian

[ ]  Hispanic, Latino, or Spanish

[ ]  Native Hawaiian or Other Pacific Islander

[ ]  White

[ ]  Prefer to self-describe

[ ]  Unknown or prefer not to say

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| Education/Services |  | Please list locations |
| Current educational service level?  | [ ]  EI[ ]  Preschool[ ]  Pre-K[ ]  K-5[ ]  6-8[ ]  9-12 (+)[ ]  higher education | Click or tap here to enter text. |
| Past participation in EI, pre-school or special education in the past (list all that apply) | [ ]  Yes [ ]  No | Click or tap here to enter text. |
| Current Special Education services | [ ]  Yes [ ]  No | Click or tap here to enter text. |

## Personal Factors

Preferred language Click or tap here to enter text.

Family’s preferred language Click or tap here to enter text.

Primary means of communication Click or tap here to enter text.

Sign language or language interpreter needed for this visit [ ]  Yes [ ]  No

Are there any social/emotional concerns that affect your family [ ]  Yes [ ]  No Click or tap here to enter text.

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| Environmental Factors |  | Please list |
| Use of any orthotics, assistive or adapted devices/technology  | [ ]  Yes [ ]  No | Click or tap here to enter text. |
| Barriers in the home setting, such as stairs, that limit independently movement throughout the home | [ ]  Yes [ ]  No | Click or tap here to enter text. |
| Barriers in the school setting that limit independent movement throughout the school | [ ]  Yes [ ]  No | Click or tap here to enter text. |
| Adequate access to transportation | [ ]  Yes [ ]  No | Click or tap here to enter text. |
| Adequate access to healthcare providers | [ ]  Yes [ ]  No | Click or tap here to enter text. |

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| Individual’s Medical History |  | Please list  |
| Primary diagnosis or diagnoses  | [ ]  Yes [ ]  No | Click or tap here to enter text. |
| Concerns about development | [ ]  Yes [ ]  No | Click or tap here to enter text. |
| Issues that affect health/function/movement | [ ]  Yes [ ]  No | Click or tap here to enter text. |
| Precautions/contraindications to movement/ positioning | [ ]  Yes [ ]  No | Click or tap here to enter text. |
| Current (or previous) primary care provider or agency | [ ]  Yes [ ]  No | Click or tap here to enter text. |
| Medical providers or practitioners (orthopedic, neurologic, GI, vision, other) | [ ]  Yes [ ]  No | Click or tap here to enter text. |
| Other health care specialists (physical/ occupational therapist, speech language pathologist, behavior specialist or other) | [ ]  Yes [ ]  No | Click or tap here to enter text. |
| Current (or past) medications | [ ]  Yes [ ]  No | Click or tap here to enter text. |
| Past hospitalizations or surgery  | [ ]  Yes [ ]  No | Click or tap here to enter text. |
| Are immunizations up to date | [ ]  Yes [ ]  No | Click or tap here to enter text. |
| Has hearing been tested (If so, when) | [ ]  Yes [ ]  No | Click or tap here to enter text. |
| Currently wearing hearing aids or cochlear implants | [ ]  Yes [ ]  No | Click or tap here to enter text. |
| Has vision been tested | [ ]  Yes [ ]  No | Click or tap here to enter text. |
| Currently wearing glasses | [ ]  Yes [ ]  No | Click or tap here to enter text. |

##

# Individual’s and Family’s Medical History:

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| --- | --- | --- | --- |
| Conditions (check all that apply): | Child | Family | Details |
| Allergies | [ ]  | [ ]  | Click or tap here to enter text. |
| Bowel problems | [ ]  | [ ]  | Click or tap here to enter text. |
| Bone fractures | [ ]  | [ ]  | Click or tap here to enter text. |
| Blood disorder | [ ]  | [ ]  | Click or tap here to enter text. |
| Breathing or lung conditions | [ ]  | [ ]  | Click or tap here to enter text. |
| Cancer | [ ]  | [ ]  | Click or tap here to enter text. |
| Circulation/vascular problems | [ ]  | [ ]  | Click or tap here to enter text. |
| Dental caries (cavities) | [ ]  | [ ]  | Click or tap here to enter text. |
| Depression/anxiety/other mental health concerns | [ ]  | [ ]  | Click or tap here to enter text. |
| Developmental or growth problems | [ ]  | [ ]  | Click or tap here to enter text. |
| Diabetes/high blood sugar | [ ]  | [ ]  | Click or tap here to enter text. |
| Difficulty swallowing | [ ]  | [ ]  | Click or tap here to enter text. |
| Fatigue/Muscle Weakness | [ ]  | [ ]  | Click or tap here to enter text. |
| Hypoglycemia/Low blood sugar | [ ]  | [ ]  | Click or tap here to enter text. |
| Headaches | [ ]  | [ ]  | Click or tap here to enter text. |
| Heart problems (including palpitations) | [ ]  | [ ]  | Click or tap here to enter text. |
| High blood pressure | [ ]  | [ ]  | Click or tap here to enter text. |
| Infectious disease (e.g., tuberculosis, COVID-19) | [ ]  | [ ]  | Click or tap here to enter text. |
| Joint pain or swelling | [ ]  | [ ]  | Click or tap here to enter text. |
| Kidney or urinary disease | [ ]  | [ ]  | Click or tap here to enter text. |
| Liver disease | [ ]  | [ ]  | Click or tap here to enter text. |
| Loss of balance | [ ]  | [ ]  | Click or tap here to enter text. |
| Muscle tone condition or unusual movements | [ ]  | [ ]  | Click or tap here to enter text. |
| Seizures/epilepsy | [ ]  | [ ]  | Click or tap here to enter text. |
| Stroke | [ ]  | [ ]  | Click or tap here to enter text. |
| Thyroid problems | [ ]  | [ ]  | Click or tap here to enter text. |
| Ulcers/stomach problems | [ ]  | [ ]  | Click or tap here to enter text. |
| Unexplained nausea/vomiting |[ ] [ ]  Click or tap here to enter text. |
| Other |[ ] [ ]  Click or tap here to enter text. |

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| Individual and Family Goals and Aspirations/Quality of Life |  |
| Favorite or enjoyable activities | Click or tap here to enter text. |
| Examples of activities to participate in or perform better | Click or tap here to enter text. |
| Current Health Profile and Behaviors |  |
| **Physical activity** (Physical Activity Guidelines: [CDC, 2019](https://health.gov/sites/default/files/2019-09/Physical_Activity_Guidelines_2nd_edition.pdf)): |  |
| Average time per day engaged in moderate to vigorous physical activity  | [ ]  <30 min [ ]  30–60 min [ ]  1–2 hr [ ]  2–3 hr [ ]  >3 hr  |
| Participation in sports | [ ]  Yes [ ]  No Click or tap here to enter text. |
| Time spent sitting per day | Click or tap here to enter text. |
| Muscle-building and balance activities per day | Click or tap here to enter text. |
| **Sleep** (Pediatric Consensus Statement on Sleep, [AAP, 2016](https://www.healthychildren.org/English/news/Pages/AAP-Supports-Childhood-Sleep-Guidelines.aspx)) |  |
| Average hours of sleep per day (including naps) | Click or tap here to enter text. |
| Sleep habit concerns | Click or tap here to enter text. |
| A TV or other screen in individual’s room | Click or tap here to enter text. |
| **Nutrition** (Dietary Guidelines, [CDC 2015-2020](https://www.cdc.gov/healthyschools/nutrition/facts.htm)) |  |
| Well-balanced diet (to include fruits/vegetables) | [ ]  Yes [ ]  No Click or tap here to enter text. |
| Adequate fluid intake | [ ]  Yes [ ]  No |
| Average number of sugary drinks or juice per day | [ ]  0 [ ]  1 [ ]  2 [ ]  3 [ ]  4 [ ]  >4 |
| Special diet | [ ]  Yes [ ]  No Click or tap here to enter text. |
| **Parental Concerns** |  |
| Diet or weight concerns | [ ]  Yes [ ]  No Click or tap here to enter text. |
| Smoking, vaping, or using alcohol or drug concerns | [ ]  Yes [ ]  No Click or tap here to enter text. |
| Other concerns to share | [ ]  Yes [ ]  No Click or tap here to enter text. |

**Standard Physical Examination**

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| Vital Signs (norms: [pedscases, 2018](http://www.pedscases.com/pediatric-vital-signs-reference-chart)) |
| **HR:** Click or tap here to enter text.**RR:** Click or tap here to enter text. | **BP:** Click or tap here to enter text.**SaO2:** Click or tap here to enter text. |
| Body Composition ([CDC BMI guidelines](https://www.cdc.gov/healthyweight/assessing/bmi/childrens_bmi/about_childrens_bmi.html)) |
| **Height**: Click or tap here to enter text.**Weight:** Click or tap here to enter text. | **BMI:** Click or tap here to enter text.**Waist circumference:** Click or tap here to enter text. |
| Integumentary Status |  | Detail |
| History of skin conditionsVisible bruises, scrapes, abrasions, or blistersSigns of skin irritation or breakdown | [ ]  Yes [ ]  No[ ]  Yes [ ]  No[ ]  Yes [ ]  No | Click or tap here to enter text. Click or tap here to enter text.Click or tap here to enter text. |

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| Pain  |
| Presence of pain [ ] Yes [ ]  No Explain: Click or tap here to enter text. |
| Therapist method of evaluating pain/rating: Click or tap here to enter text. |

Movement System(PT will determine which tasks are age-appropriate for the individual)

**Quality of movement to observe:**

Speed of movement — time to complete the task.

Amount of movement — amplitude, excursion, ROM of movement required to complete the activity.

Symmetry of movement — there may be natural asymmetries in a task.

Control — smoothness, coordination, stability, sequencing, timing initiation.

Symptom alteration — guarded, shortness of breath, pain alteration.

\*Provocation: symptoms exacerbated or relieved with movement listed (use notes to explain).

|  |  |
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| Head Movement | Impaired Not Impaired Unable Provocation\* |
| In either sitting or standing, instruct individual to:* Look up to ceiling or sky (extension).
* Look down to floor or ground (flexion).
* Look over left and right shoulders (rotation).
* Bring left and right ear to same side shoulders (side bending/ lateral flexion).
 |  [ ]  [ ]  [ ]  [ ]   [ ]  [ ]  [ ]  [ ]   [ ]  [ ]  [ ]  [ ]   [ ]  [ ]  [ ]  [ ]  Notes: Click or tap here to enter text.  |
| Rolling | Impaired Not Impaired Unable Provocation |
| Instruct individual from supine position to:* Roll to the right.
* Roll to the left.
* Roll to prone.
 |  [ ]  [ ]  [ ]  [ ]   [ ]  [ ]  [ ]  [ ]   [ ]  [ ]  [ ]  [ ]  Notes: Click or tap here to enter text.  |

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| Lying to Sit to Lying | Impaired Not Impaired Unable Provocation |
| Instruct individual from supine position to: * Rise to sitting with feet dangling off mat/bed, then return to supine from dangling position.
 |  [ ]  [ ]  [ ]  [ ]  Notes: Click or tap here to enter text.  |
| Sit to Stand to Sit | Impaired Not Impaired Unable Provocation |
| Instruct individual in a sitting position to: * Rise to stand, then return to sitting.
 |  [ ]  [ ]  [ ]  [ ]  Notes: Click or tap here to enter text.  |
| Squatting | Impaired Not Impaired Unable Provocation |
| Instruct individual to: * Pretend to pick up a light object from the floor.
 |  [ ]  [ ]  [ ]  [ ]  Notes: Click or tap here to enter text.  |
| Crawling / Walking / Running / Wheelchair | Impaired Not Impaired Unable Provocation |
| Instruct individual to:* Move forward on hands and knees (crawling) at comfortable pace.
* Walk at a comfortable pace. \*
* Run at a comfortable pace on a treadmill or over ground.
* Self-propel at a comfortable pace in wheelchair.
 |  ☐ ☐ ☐ ☐  ☐ ☐ ☐ ☐  ☐ ☐ ☐ ☐  ☐ ☐ ☐ ☐ Notes: click to enter  |
| Step Up and Step Down | Impaired Not Impaired Unable Provocation Crawling / Walking / Running / Wheelchair |
| Instruct individual to: * Step up and down onto a single step, leading with right foot, then with left foot.
 |  [ ]  [ ]  [ ]  [ ]  Notes: Click or tap here to enter text.  |

## Hand and Arm Use

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| Reaching | Impaired Not Impaired Unable Provocation |
| Instruct individual in a sitting or standing position to:* Raise both arms over head as if reaching for an object on a high shelf.
* Put both hands behind head.
* Put both hands behind back.
 |  [ ]  [ ]  [ ]  [ ]   [ ]  [ ]  [ ]  [ ]   [ ]  [ ]  [ ]  [ ]  Notes: Click or tap here to enter text.  |
| Grasping | Impaired Not Impaired Unable Provocation |
| Instruct individual to: * Hold and release object first with right hand then with left hand (this can be any object, including therapist’s fingers).
 |  [ ]  [ ]  [ ]  [ ]  Notes: Click or tap here to enter text.  |
| Manipulating | Impaired Not Impaired Unable Provocation |
| Instruct individual, using first one hand and then the other, to: * Pick up an object and manipulate it (e.g., pick up a pencil, crayon, or toy and move it to the right).
 |  [ ]  [ ]  [ ]  [ ]  Notes: Click or tap here to enter text.  |

## Physical Performance Examination:

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| Aerobic Capacity |
| Examples: [6-Minute Walk Test](https://www.apta.org/patient-care/evidence-based-practice-resources/test-measures/6-minute-walk-test-6mwt-for-annual-checkup) Click or tap here to enter text.1-Minute Walk Test Click or tap here to enter text. 1-Minute Push Test Click or tap here to enter text. |
| Balance |
| Examples: [Single-leg stance test](https://www.apta.org/patient-care/evidence-based-practice-resources/test-measures/single-leg-stance) (eyes open/closed) Click or tap here to enter text.[Pediatric Balance Scale](https://physio-pedia.com/Pediatric_Balance_Scale?utm_source=physiopedia&utm_medium=search&utm_campaign=ongoing_internal) Click or tap here to enter text. |
| Flexibility/Functional Range of Motion |
| Examples:Functional range of motion screen Click or tap here to enter text.90/90 passive popliteal/hamstring flexibility Click or tap here to enter text.Straight leg raise Click or tap here to enter text. Other Click or tap here to enter text. |
| Strength and Muscle Tone |
| Functional strength assessment: Click or tap here to enter text.Muscle tone**:** [ ]  Normal [ ]  Abnormal Describe: Click or tap here to enter text.Other: Click or tap here to enter text. |
| Sensation |
| Complete based on response to light touch/observation.Click or tap here to enter text. |

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| Posture |
| Asymmetries or abnormalities observed during the movement screen? Click or tap here to enter text. |
| MotorDevelopment[CDC Milestones](https://www.cdc.gov/ncbddd/actearly/milestones/index.html) |
| Age-appropriate motor development? Click or tap here to enter text. |

# Summary

Summarize major findings of screen:

Click or tap here to enter text.

## Plan/recommendations (check off all that apply)

[ ]  Date of next check-up. Click or tap to enter a date.

[ ]  Physical therapist services are indicated without additional evaluation. Explain: Click or tap here to enter text.

[ ]  Child would benefit from additional evaluation in the following body system areas:

[ ]  Cardiovascular/pulmonary [ ]  Musculoskeletal [ ]  Integumentary [ ]  Neuromuscular

[ ]  Child/family would benefit from referral to another professional (e.g., medical, educational, therapeutic technologies, social, community agencies; include discipline and contact information of service provider if known). Click or tap here to enter text.

[ ] Reason for referral Click or tap here to enter text.

[ ]  Other Click or tap here to enter text.