Patient Name: Date of Birth:
Today's date: Diagnosis:

Therapy Summary:

	Visits per month?	Minutes per visit?	Provider/Clinic Name
Physical Therapy Outpatient Home School	 1 2 3 4 5 6 7 8 9 ____ 1 2 3 4 5 6 7 8 9 ____ 1 2 3 4 5 6 7 8 9 ____	 15 30 45 60 _____ 15 30 45 60 _____ 15 30 45 60 _____	______ ______ ______
Occupational Therapy Outpatient Home School	 1 2 3 4 5 6 7 8 9 ____ 1 2 3 4 5 6 7 8 9 ____ 1 2 3 4 5 6 7 8 9 ____	 15 30 45 60 _____ 15 30 45 60 _____ 15 30 45 60 _____	______ ______ ______
Speech Therapy Outpatient Home School	 1 2 3 4 5 6 7 8 9 ____ 1 2 3 4 5 6 7 8 9 ____ 1 2 3 4 5 6 7 8 9 ____	 15 30 45 60 _____ 15 30 45 60 _____ 15 30 45 60 _____	______ ______ ______
Hippotherapy	1 2 3 4 5 6 7 8 9 ____	15 30 45 60 _____	
Aquatic Therapy	1 2 3 4 5 6 7 8 9 ____	15 30 45 60 _____	
Feeding Therapy	1 2 3 4 5 6 7 8 9 ____	15 30 45 60 _____	
Vision Therapy	1 2 3 4 5 6 7 8 9 ____	15 30 45 60 _____	
Music Therapy	1 2 3 4 5 6 7 8 9 ____	15 30 45 60 _____	
Other:			

Equipment (fill in details for all that apply)

Equipment Type	***Description***	***How Often is it used?*** ***(minutes/hours/days per week)***
Wheelchair/Stroller		
Walker/Gait Trainer		
Standing Frame		
Bath Chair		
Car Seat		
Hospital Bed		
Orthotics		
E-stim		
Communication Device		
Other:		

Equipment Concerns/Needs: ______________________________

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Patient Name: ______________________________________

Physical Therapy Focus for Home Program (Circle all that apply):

Balance | Fitness/Endurance | Walking | Stair Climbing
Transfers | Wheelchair Training | Self-feeding | Coordination

Strengthening (List muscles):____

Stretching (include upper extremity here-wrists, hands, etc.):

Muscle	**Equipment**	**Time**
Ex: Hamstrings	Knee immobilizers	nightly
Ex: Ankles	Stretched by parent	Daily for 10 minutes

Standing (list time/equipment):____

Riding Bike (time):_____ Walking (time):______ Running (time):_______

Swimming (time):_____ Treadmill (time):______

Camps/Sports:____

Other:

Speech Therapy Focus for Home Program (circle all that apply):

Articulation | Swallowing | Strengthening | Stretching | Feeding
Communication Device | Other:

Occupational Therapy Focus for Home Program (circle all that apply):

Fine Motor Coordination | Bilateral Coordination | Handwriting | Trunk control/strength
Augmentative Comm | Sensory Integration | ADLs | Cooking
Dressing | Computer Access | Feeding | Keyboarding
Other:

My child can (circle all that apply):

___Hold up head in sitting
___Hold up his/her head on stomach
___Brings hands together
___Roll back to side
___Roll side to back
___Roll side to stomach
___Roll back to stomach
___Roll stomach to back
___Sit supported
___Sit without support
___Get up from the floor with support
___Get up from the floor independently
___Get in/out of wheelchair with help
___Get in/out of wheelchair without help
___Stand with support
___Stand without support
___Walk with support
___Walk without support
___Run with support
___Run without support
___Climb stairs with support
___Climb stairs without support
___Stand on 1 foot
___Jump
___Jump on 1 foot

My Goals for Therapy Are: