



194 Francisco Lane, Suite 104
Fremont, CA 94539
(510) 656-3777
FAX: (510) 656-3750
www.espt-ca.com

Elite Sports Physical Therapy

PARENT/GUARDIAN CONSENT TO EXCHANGE/RELEASE INFORMATION

Child's Name: _____ Date of Birth: _____

I _____ give my consent for exchange of information and to have my
(Parent/caregiver-please print name)

child's records and medical information related to the referral for pediatric physical therapy

(neurologic,orthopedic, developmental reports) released from:

_____ MD

to: **Elite Sports Physical Therapy**
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Signature of Parent/Guardian Date Phone



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PEDIATRIC OUTPATIENT PHYSICAL THERAPY HEALTH HISTORY

Personal Information	
Child's Name	DOB
Parent's Name(s)	
Consent Signed? Yes No	Prescription? Yes No Immunizations current? Yes No
Referral	
Reason for Referral/Concerns	
Referring Physician/Address/Phone	
Medical Diagnoses & onset	
Special Tests Completed	Approximate Date & Result (if impacting current function)
MRI, CT, Blood work	
Surgeries	
Other	
Birth History	
Height & weight at birth	
Pregnancy Complications	
Premature (weeks' gestation)	Post-birth complications
Did your child go home with oxygen or other tubes? How long?	Any other serious illnesses/infections since birth?
Current Medical	
Height & weight	
Growth Issues	Yes (explain) No
Feeding Issues	Yes (explain) No
Sleeping Issues	Yes (explain) No
Sensory Issues	Yes (explain) No
Hearing	Last check_____ Tubes? Yes No Hearing aids? Yes No Implant? Yes No
Vision	Last check_____ Corrective lenses? Vision therapy?
Allergies (please specify)	



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CHILD'S NAME:	DOB:
Medications-list & reason taking	
Additional Systems If problem, please explain briefly	
Review	
Thyroid	
Heart	
Lungs	
Stomach	
Kidney/Urinary	
Constipation	
Seizures	
Spasms	
Bleeding	
Asthma	
Eczema/other skin problem	
Joints/Bones/Muscles	
Infections	
Social/Living Situation Family, Siblings, House/Apt, Stairs	
Child's School Name of Center/School/Daycare-Frequency-Times	
Developmental Age in Months When Achieved	
Rolling	
Sitting Alone	
Crawling hands and knees	
Walking alone	
Running	
Jumping	



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Stair Climbing	
Holds bottle or toys	
CHILD'S NAME:	DOB:
Describe other developmental problems:	

Other Specialists Caring for Your Child	Special Findings or Comments from Last Exam
Neurologist	
Orthopedist	
Cardiologist	

Additional Concerns/Comments/
What you hope your child can achieve with physical therapy