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### Pediatric PT Questionnaire

Child's name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

What are your primary concerns or goals regarding your child?

What are your child's strengths?

Has your child ever had significant medical conditions? Please explain

Surgery -

Hospitalization -

Seizures -

Allergies -

Other -

Is there anything else we should know?

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date