Tidewater Therapy for Children, PC

PEDIATRIC INFORMATION QUESTIONNAIRE

Child's Name:_____ Date of Birth:_____
Mother's Name: _____ Age: _____
Mother's Occupation:_____ Cell/Home Phone:_____
Father's Name: _____ Age: _____
Father's Occupation: _____ Cell/ Home Phone: _____
Home Address:_____
Siblings (including names, ages, and any medical issues)
_____
Pediatrician: _____Phone:_____

GENERAL INFORMATION

What languages does the child speak? What is the primary language?
_____

What is the primary language spoken at home? _____

With whom does the child spend most of his/her time? _____

How does the child usually communicate (gestures, single words, short phrases, sentences):
_____

How does the child usually move around? (crawl, walk, tip-toe, etc.)_____
_____

Describe your concerns regarding the child (what brings you in today?)_____
_____
_____

What would you like to see the child be able to do:_____
_____
_____

When were these issues first noticed? By Whom?_____
_____

Have these issues changed since they were first noticed?_____

Is the child aware of this? If yes, how does the child feel about it?_____
_____

Has the child seen any other specialists regarding these issues? If yes, please explain.
_____
_____

Is there a family history of speech, language, hearing, sensory processing, or other related problems to those the child is currently experiencing? If yes, please explain_____
_____

- Family history / diagnosis of: ___ ADD ___ADHD ___Autism Spectrum

Please explain_____

PRENATAL AND BIRTH HISTORY

Please describe the mother's health during pregnancy (illness, accident, medication, etc)

_____

_____

Length of pregnancy:_____ Length of Labor: _____

General condition: _____ Birth Weight: _____

Were there any conditions that may have affected the pregnancy or birth?

_____

_____

MEDICAL HISTORY

Please provide approximate age at which child suffered any of these conditions/illnesses

Allergies		Dizziness		High Fever		Pneumonia	
Asthma		Draining Ear		Influenza		Seizures	
Chicken Pox		Ear Infections		Mastitis		Sinusitis	
Colds		Encephalitis		Measles		Tinnitus	
Convulsions		German Measles		Meningitis		Tonsillitis	
Croup		Headaches		Mumps		Other	

Has the child had any surgeries? If yes, what type and when (tonsillectomy, tube placement, etc)

_____

_____

Describe any major accidents or hospitalizations.

_____

_____

Is the child taking any medications? If yes, please identify.

_____

_____

Has there ever been a negative reaction to any medication? If yes, please explain.

_____

_____

DEVELOPMENTAL HISTORY

Can your child do the following activities?

	Yes	**No**	**At What Age Did They Do This Activity?**
Crawl			
Sit			
Stand			
Walk			
Feed Self			
Dress Self			
Use Toilet			
Use Single Words (mama, dada, doggie)			
Combine words (me go, more juice)			
Name simple objects (dog, car, book)			
Use simple questions (Where's doggie?)			
Engage in conversation			

Does your child show hand dominance?

Please circle: Left Right None

Does (or did) the child have any difficulty walking, running or participating in other activities that require *small* or *large* muscle coordination?

_____
_____

Are there or has there ever been any feeding problems (e.g. problems with sucking, swallowing, drooling, chewing, choking)?

_____
_____

Is the child a "picky" eater? Are there any foods/textures the child will not/did not *eat* or *touch*?

_____
_____

Please describe the child's response to sound (e.g. responds to all sounds, to loud sounds only, inconsistently responds to sound)

_____
_____

EDUCATIONAL HISTORY

School _____ Grade_____
Teacher _____

How is the child doing academically (or pre-academically) / Areas of difficulty?

_____
_____

How does the child interact with others (e.g. shy, aggressive, uncooperative)?

_____
_____

Does the child receive special services? If yes, please explain.

_____
_____

If enrolled for special educational services, has an Individual Education Program (IEP) been developed? If yes, please describe the most important goals.

_____
_____
_____

Please provide any additional information that may be helpful in the evaluation. **(IE any food allergies, latex, etc.)**

_____
_____
_____

Completed by: _____ Relation to child_____

Signature_____ Date _____