Pediatric Questionnaire

Today's Date:_____
Child's Name:_____
Date of Birth:_____
Sex (circle): Male or Female

Pediatrician/primary medical care provider:
Name:_____
Phone:_____
Date last seen on:_____

Mother/Guardian:	Father/Guardian:
Date of birth:	Date of Birth:
Address:	Address:
Phone: Carrier (i.e. Verizon)	Phone: Carrier (i.e. Verizon)_____
Email:	Email:
Employer (*name*):	Employer (*name*):
Address:	Address:
Phone:	Phone:

Child's Legal Guardian _____

Does your child have any medical diagnoses:

_____

What are your present concerns?

_____

Has the problem changed? (Gotten better or worse?)

_____

Medical History

Please note any of your child's medical, developmental and/or mental health concerns/diagnoses:

Frequently sick? (in general)	Past	Present (briefly describe) _____
Ear infections?	Past	Present (briefly describe) _____
Sinusitis?	Past	Present (briefly describe) _____
Diarrhea?	Past	Present (briefly describe) _____
Constipation?	Past	Present (briefly describe) _____
Bronchitis?	Past	Present (briefly describe) _____
Pneumonia?	Past	Present (briefly describe) _____
Cannot breath through nose?	Past	Present (briefly describe) _____
Snoring or noisy breathing?	Past	Present (briefly describe) _____
Esophagitis?	Past	Present (briefly describe) _____

Neurologic (brain) issues?	Past	Present (briefly describe) _____
Renal(kidney) issues?	Past	Present (briefly describe) _____
Autism/PDD?	Past	Present (briefly describe) _____
Mental health issue? (specify)	Past	Present (briefly describe) _____
Genetic/chromosome abnormality?	Past	Present (briefly describe) _____
Failure to thrive/slow growth?	Past	Present (briefly describe) _____
Pulmonary (lung) issues (asthma)?	Past	Present (briefly describe) _____
Slow stomach emptying?	Past	Present (briefly describe) _____
Cardiac (heart) issues?	Past	Present (briefly describe) _____
Trouble sleeping?	Past	Present (briefly describe) _____
Gastroesophageal reflux?	Past	Present (briefly describe) _____
Swallowing difficulties?	Past	Present (briefly describe) _____
Chewing difficulties?	Past	Present (briefly describe) _____
Gag, cough, choking difficulties?	Past	Present (briefly describe) _____
Pain or discomfort during feeding?	Past	Present (briefly describe) _____
Seizures?	Past	Present (briefly describe) _____
Surgeries?	Past	Present (briefly describe) _____

Are you giving your child any medications, herbs or vitamins? If yes please list all supplements, herbs, medications, over the counter medications

Medication	**Dose**	**How often**

Is your child allergic to or does he/she react to the following?

- ❑ Prescription medications (reaction)_____
- ❑ Over the counter medications (reaction) _____
- ❑ Foods, food additives or drink (reactions) _____
- ❑ Latex or anything else such as bandages or tape (reactions)_____
- ❑ X-ray, CT, MRI, or other radiology dyes (reactions) _____
- ❑ Blood products (reaction)_____
- ❑ None known

Are your child's immunizations up to date? ❑ Yes ❑ No

Birth History

Was alcohol or any drug (including prescriptions) used before or during pregnancy? ___Yes (please describe) ___No

_____

Gestational Age at time of delivery (or # weeks early or late): _____

Length of Labor (in hours)? _____

Any type of labor stimulation and what was used? _____

Any type of pain medication or anesthesia used during delivery (name, type, amount if known)?

Pain relief Anti-vomiting

Sedation Anesthesia

What type of delivery (please circle)? Vaginal Cesarean Section (circle): elective, emergency

Presentation (circle): Head, Face, Breech, Transverse Reason for C-section _____
Assistance (circle): Forceps, Vacuum, other _____

Did you experience any problems during the labor/delivery? _____

What was the condition of your infant while in the nursery? Please indicate by placing a checkmark in the "no" or "yes" column and explain (what month, why, what, what occurred, how treated etc.):

NO	YES	DESCRIPTION	EXPLANATION
		Was blue/cyanotic at birth	
		Required stimulation to breathe	
		Required oxygen at birth	How much/what type?
		Required resuscitation	
		Was considered small for gestational age	
		Had tremoring or seizures	Which/for how long?
		Very low tone	
		Brain hemorrhage	
		Anemia and/or transfusions	Which/how many times?
		Jaundice (yellow)	How much/how treated?
		Had bruising	
		Rh incompatibility problems	
		Infections	
		Congenital birth defects	
		Aspiration (meconium or fluid)	Which/how treated?
		Respiratory distress signs or syndrome	
		Needed ventilation	What type/how long?
		Choking or vomiting episodes	
		Tube feedings	
		Needed medications	

Developmental History

We would like to have information about your child's developmental milestones. Please mark whether you believe your child accomplished the milestones early, on time or late. If your child has not yet achieved the milestone, check N/A.

MILESTONE	Early	On Time	Late	N/A
Gross motor milestones:				
• Rolled over (3-6 months)	❑	❑	❑	❑
• Sat unsupported (6-9 months)	❑	❑	❑	❑
• Crawled (9 months)	❑	❑	❑	❑
• Stood alone (10-12 months)	❑	❑	❑	❑
• Walk by self (18 months)	❑	❑	❑	❑
Fine motor milestones:				
• Transferred object between hands (6 months)	❑	❑	❑	❑
• Feeds self finger foods (8 months+)	❑	❑	❑	❑
• Helps with undressing (1 year)	❑	❑	❑	❑
• Snips with scissors (2 years)	❑	❑	❑	❑
• Pedals tricycle (2-3 years)	❑	❑	❑	❑
• Catches ball (2 years)	❑	❑	❑	❑
Cognitive:				
• Identifies some letters and letter sounds (3-4)	❑	❑	❑	❑
• Understands idea of counting (4 years)	❑	❑	❑	❑

• Potty training (1.5-3 years)	❑	❑	❑	❑
Speech/Language: • Coos, babble, vocal play (0-6 months) • Points to objects (7-12 months) • Use first words (12-18 months) • Uses two words together (1-2 years) • Follows 1-part directions, like "Roll the ball" or "Kiss the baby." (1-2 years) • Follows 2-part directions, like "Get the spoon and put it on the table." (2-3 years)	❑ ❑ ❑ ❑ ❑ ❑	❑ ❑ ❑ ❑ ❑ ❑	❑ ❑ ❑ ❑ ❑ ❑	❑ ❑ ❑ ❑ ❑ ❑

How does your child currently communicate?

Body language (pointing, gesturing, facial expressions, pulling, tugging)	Two-word sentences (e.g. "more juice")	Other: _____
Sounds (vowels, grunting)	Three to four-word sentences ("I want ball")	
Single words (e.g. "juice", "horsey")	Sentence longer than four words	

Please check if your child has received any of the following:

- ❑ Hearing evaluation When: _____ Where: _____Concerns? _____
- ❑ Vision evaluation When: _____ Where: _____ Concerns? _____
- ❑ Occupational Therapy evaluation When: _____ Where: _____ Concerns? _____
- ❑ Speech/Language Evaluation When: _____ Where: _____Concerns? _____
- ❑ Physical Therapy Evaluation When: _____ Where: _____ Concerns? _____

Does your child attend daycare or spend time with a caretaker other than parents for a large portion of the day or evenings? If yes, please describe:

_____

What other activities does your child attend regularly (including preschool, childcare, speech therapy, community activities, other therapies)? Please include location and frequency.

_____

_____

Has your child had problems with any of the following (beyond expected for child's age):

NO	YES	DESCRIPTION	EXPLANATION
		Sleeping problems	
		Bed wetting	
		Drooling	
		Thumb sucking	
		Temper tantrums	
		Head banging	
		Breath holding	
		Aggression/destructiveness	
		Nervous habits (nail biting etc)	
		Masturbation	

		Fire play or cruelty to animals	
		Major mood swings	
		Under or over reactive to sounds	
		Under or over reactive to clothing	
		Under or over reactive to taste	
		Under or over reactive to smell	
		Any unusual fears?	

Family and Social History

Child lives with (Check all that apply):

- ❑ Birth parents
- ❑ One parent
- ❑ Adoptive parents
- ❑ Foster parents
- ❑ Parent and step-Parent
- ❑ Other:_____

Family's primary language _____

Any family history of speech, language, cognitive, learning, or feeding difficulties? _____

Other children in the family:

Name Age Sex Any developmental concerns?

_____

_____

_____

Nutrition/Feeding/Swallowing History

Was the child fed through a feeding tube? If yes, for how long?

_____

_____

On average how long does it take the child to eat?

_____

Do you have concerns about your child's eating?

_____

What kinds of foods or liquids can your child eat most of the time?

- ❑ Breast milk
- ❑ Mashed table food
- ❑ Regular table food
- ❑ Formula
- ❑ Chopped table food
- ❑ Other:_____
- ❑ Liquids (Circle: thin, nectar, honey, pudding thick?)

Please indicate the age at which you child demonstrated each skill:

_____ Cup drinking _____Drinking with straw _____Eat solid foods

Does your child feed himself/herself? ___Yes ___No

If yes, how?

- ❑ Fingers
- ❑ Spoon or fork
- ❑ Cup/glass
- ❑ Straw

Please check all that apply to your child:

- ❑ Choking during meal
- ❑ Cries during meals
- ❑ Food or liquid coming out of the nose
- ❑ Eats too much
- ❑ Difficulty swallowing
- ❑ Trouble breathing during feeds
- ❑ Spitting out food
- ❑ Eats too little
- ❑ Reflux during/after meals
- ❑ Refuses oral feeds
- ❑ Throwing up during/after meals
- ❑ Falling asleep during feeds
- ❑ Postural changes during feeds

_____STOP HERE IF YOUR CHILD DOES NOT ATTEND SCHOOL _____

School History

If your child is in preschool, elementary or high school please answer the following:

Name of school: _____

Teacher's name: _____

Please mark if your child receives extra help (e.g., small-group instruction) in the following areas:

- ❑ Math
- ❑ Writing
- ❑ Reading

Does your child receive speech or language therapy services in the school setting? ___Yes ___No

Has your child repeated a grade? ___Yes___No

Please list your child's academic strengths:

_____
_____
_____

Is your child having difficulty with any subjects?

_____
_____
_____

Additional Comments:

_____
_____