PEDiATRIC INFORMATION QUESTIONNAIRE

Patient Name: ________________________________________________ Today’s Date: ____________________

Date of Birth: ________________________      Age: _________________  Sex:  ☐ Male  ☐ Female

Medical Diagnosis: _________________________________________________________________________________

Parent Concern: ___________________________________________________________________________________

Pediatrician: ______________________________________________________________________________________

Other Physicians for this Patient: _____________________________________________________________________

Other Agencies Involved with Child (i.e. Early Steps/CMS): ______________________________________________

Who Referred You? ________________________________________________________________________________

MEDICAL HISTORY Check any of the following which your child has/had problems with:

☐ Swallowing / Choking  ☐ Vision  ☐ Serious Illness
☐ Tonsils or Adenoids  ☐ Surgeries  ☐ Serious Accidents
☐ Seizures or Convulsions  ☐ High Fever  ☐ Frequent Colds
☐ Lost consciousness  ☐ Hospitalization  ☐ Ear Infections

PAIN ASSESSMENT:
Do you feel that pain/discomfort interferes with your child’s function?  ☐ No  ☐ Yes
(Details)________________________________________________________

Do you feel that pain/discomfort will interfere with your child’s participation in rehabilitation?  ☐ No  ☐ Yes
(Details)________________________________________________________

How does your child express pain?  How do you know when they are in pain? ______________________________
_______________________________________________________________

BIRTH INFORMATION
Was your child born before his/her due date?  ☐ Yes  ☐ No

Number of Weeks Gestation: ________________________  Birth Weight: _________________________________

Please specify any difficulties during pregnancy or delivery: __________________________________________________
_______________________________________________________________

Please specify any difficulties during newborn period: ______________________________________________________
_______________________________________________________________

SOCIAL HISTORY
Who Lives with the Child? ______________________________________

Siblings & Ages: ______________________________________________

Name of School/Daycare: _________________________________________

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DEVELOPMENT
Age Sat Alone: ______________  Age Walked Alone: _______________  Age Toilet Trained: ___________
Child’s Physical Development: ☐ Fast  ☐ Normal  ☐ Slow
Child’s Coordination: ☐ Good  ☐ Clumsy

BEHAVIORAL OVERVIEW Please check ANY of the following that describes the behavior of your child:

☐ Nervous or sensitive  ☐ Unusual fears  ☐ Temper tantrums
☐ Overly talkative  ☐ Wets bed  ☐ Thumb sucker
☐ Restless sleeper  ☐ Shy  ☐ Behavior problems
☐ Slow learner  ☐ Overly active  ☐ Short attention span
☐ Demands attention  ☐ Cries easily  ☐ Plays well with playmates
☐ Easily managed  ☐ Withdrawn  ☐ Resists certain positions
☐ Prefers to play alone  ☐ Feeding problems  ☐ Does not get along with playmates
☐ Requires extensive help to fall asleep  ☐ Other ______________________________

UNDERSTANDING LANGUAGE When you talk to your child, how much does he/she understand? Check one:
☐ A few words  ☐ Simple directions  ☐ Many words and phrases  ☐ Almost everything I say
Additional Comments: _____________________________________________________________________________

What language is spoken most frequently at home: _____________________________________________________

EXPRESSIVE COMMUNICATION How does your child usually let you know what he/she wants?
Check all that apply:
☐ Cries  ☐ Uses a few words  ☐ Points to what he/she wants
☐ Uses long sentences  ☐ Makes a few sounds  ☐ Makes different sounds
☐ Uses gestures (i.e. gestures for “give it to me”)  ☐ Says two or three word sentences
☐ Says many words, but only says one word at a time
☐ Speaks in sentences, but is hard to understand
Additional Comments/Examples: _________________________ ____________________________________________

SLEEP INFORMATION
How many hours a night does your child sleep? _________________________________________________________

How many naps does your child take during the day? ____________________ For how long? _________________

PRIOR THERAPY
☐ Physical Therapy  ☐ Occupational Therapy  ☐ Speech Therapy
☐ Other _________________________________________________________________________________________

Dates: _______________________________ Locations: ____________________________________________

HOME EQUIPMENT
☐ Cane(s)  ☐ Wheelchair  ☐ Walker(s)  ☐ Stander
☐ Braces  ☐ Adaptive seating  ☐ Splints  ☐ Bath/shower chair
☐ Other ______________________________

PREFERRED LEARNING STYLE We are here to teach you to teach you and your child. How do you learn best?
☐ By watching  ☐ By listening  ☐ By practicing exercises together
☐ By reading  ☐ By looking at pictures

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