TALLAHASSEE MEMORIAL HEALTHCARE

Pediatric (850) 431-4445
1425 Village Square
Suite 3
Tallahassee, FL 32312

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☐ **Easily managed**	☐ **Withdrawn**	☐ **Resists certain positions**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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