MedStar Georgetown University Hospital

Physical Medicine & Rehabilitation

Pediatric Occupational Therapy, Physical Therapy, & Speech Language Pathology

Pediatric History Questionnaire

This form has important questions that help the therapists understand your child. Please fill in all areas that you can. ***Please bring any medical reports you have for our records.***

Completed by (Name/relationship to patient): ________________________Date:_____________
Child's Name: _________________________________ Date of Birth: ___________ Age: ______
Address: ____
Main language used at home: __________ Other languages used: ________________
Email: __________________________ Secondary Email: ______________________________
Preferred Daytime Phone Number: (___)____________ ❒ Additional Phone Number:____________

Why are you coming for an evaluation? What are your main concerns?

____
____
____

Has your child been previously evaluated or treated by an occupational therapist, physical therapist, or speech-language pathologist? Date(s) of Evaluation(s)?

____
____

Please indicate any known adverse/allergic drug and/or food allergies (e.g., penicillin, latex, gluten):

____
____

Family History

Please indicate who lives at home and/or cares for your child (including yourself):

Name	Relationship to Child (parent, sibling, nanny)	Contact Numbers	Medical Diagnoses	Occupation
		Home:_______________ Cell:________________		
		Home:_______________ Cell:________________		
		Home:_______________ Cell:________________		
		Home:_______________ Cell:________________		
		Home:_______________ Cell:________________		

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Family Medical History

❒ Biological Child ❒ Adoption ❒ Foster care ❒ Surrogacy

Age at adoption/foster care placement: __________

Additional information: ____

____

Pregnancy

❒ Complications: ____

____

❒ Medications taken during pregnancy: ______________________________

❒ Prenatal exposure to ❒ alcohol ❒ tobacco ❒ drugs ❒ other: _______________

❒ Maternal hospitalizations: because of ______________________________

From _______ weeks gestation to ______ weeks gestation

❒ Breech Position

❒ Other: ____

Birth

Name of Hospital: _________________________ Length of Stay: _______________

Born at _______ weeks gestational age.

❒ Vaginal birth ❒ Difficult Labor______________ ❒ Other: ___________________

❒ C-section reason: ____

❒ Birth Weight: ____________________ Apgar Scores: ________________________

❒ Complications: ____

Neonatal

❒ NICU stay Hospital: _________________________ Length of Stay: ___________

❒ Ventilator/Breathing Tube

❒ Oxygen tube

❒ Retinopathy of Prematurity

❒ Difficulty Feeding

❒ Physical/Occupational Therapy

❒ Speech Therapy

❒ Seizures

❒ Intraventricular Hemorrhage (IVH) Grade_____

❒ Reflux/Gastroesophageal Reflux Disease (GERD)

❒ Periventricular Leukomalacia (PVL)

❒ Additional Diagnoses: ____

❒ Hearing Screening Results: ❒ Pass ❒ Fail

❒ Vision Screening Results: ❒ Pass ❒ Fail

Current Medical Status

Please tell us all **other doctors or specialists** involved in your child's care:

Specialty of Physician (ENT, GI, Geneticist)	**Name of Physician (First and Last)**	**Date Last Seen**	**Phone Number(s)**	**Fax Number**
Pediatrician				

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Please list all **medical diagnoses** your child has:

Diagnosis	Age at time of Diagnosis	Name of Physician who Diagnosed

Please list all **medications** your child takes:

Medication	Dosage	Route (oral,nasal)	Frequency	Physician who prescribed	Start Date	Stop Date

Does your child wear glasses or have difficulty seeing? ____________________ (Please describe)
Results of last **hearing** evaluation: __________________________ Date: _________________
Results of last **vision** evaluation: ___________________________ Date: _________________

Please **list any special tests, procedures, and/or hospitalizations** since birth (MRI, EEG):

Date	Procedure	Reason for Testing	Results of Procedure

Development

Please write the age when your child first performed the following skills (circle months or years)

Sat alone: __________(Months/Years)
Crawled: ___________ (Months/Years)
Walked: ___________ (Months/Years)
Babbled: ___________ (Months/Years)
Used a cup: _______ (Months/Years)
Pulled to stand: ____ (Months/Years)

Toilet-trained: _________________(Months/Years)
Learned to Write:______________(Months/Years)
Said a single word: ___________ (Months/Years)
Dressed Self:________________(Months/Years)
Finger-fed self: _______________ (Months/Years)
Used cup: ____________________(Months/Years)

Does your child use any of the following at home or at school?

❒ Walker ❒ Wheelchair ❒ Special cups/spoons ❒ Pacifier ❒ Sippy cup
❒ Assistive Technology ❒ Infant "walker" or jumper ❒ Infant Swing ❒ Exersaucer ❒ Bottle
❒ Orthotics ❒ Helmet ❒ Other: ______________________

Speech and Language

Please list any speech/language difficulties: ____
____
____
____

Have your child's language skills regressed? (Lost words, no longer follows directions)
____

Does your child repeat or echo certain words or phrases? ___________________________
____

Feeding

Please list any problems with eating: ____
____
____
____

Has your child had a swallow study given by a speech pathologist? Please include the date and test results.
____
____

Does your child have regular bowel movements? How many per day? ___ ❒Constipation ❒Diarrhea

Daycare/Preschool/School

Name:________________________________City/County__________________________________
Grade:____________ Teacher(s):____
Support Services: __________________________ Approximate # of Students in Class: __________

❒ Individual Family Service Plan (IFSP)
❒ Individual Education Plan (IEP)
❒ Adapted PE
❒ Physical therapy
❒ Occupational therapy
❒ Assistive technology
❒ Speech therapy
❒ Classroom aide
❒ Other: ____
❒ Involved in organized activities or sports? __________________________
❒ Any concerns or difficulties?____

Behavior

What are your child's favorite activities? ______________________________
What motivates your child? ______________________________________
How does child play with brothers and sisters? ❒ Poor ❒ Fair ❒ Well ❒ N/A
How does child play with children his/her own age? ❒ Poor ❒ Fair ❒ Well
What is the length of time your child can attend to an activity? ______________
Does your child have any behavior issues? _________________________
____
Does your child have any attention difficulties? _________________________
How many hours per night does your child sleep? _______________________
Does your child have difficulty falling asleep? ❒ Yes ❒ No
On average, how many times does your child wake up during the night?__________
Does your child self-feed? ❒ Finger ❒ Utensils ❒ Other_____________________
Does your child have any repetitive behaviors? (Hand flapping, rocking, lining up toys)
____
Is your child bothered by certain sensations / feelings?
❒ Noises ❒Textures, clothing, or touch ❒ Movements ❒ Lights
Please Specify: ____

Please add any other information we should know: ______________________________
____
____
____
____
____
____
____
____

THIS QUESTIONNAIRE WAS REVIEWED BY:

Therapist's Signature: _________________________________ Date: _______________

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To Be Completed by Therapist:

Time of Day	Activity (Nap, Play time, Meal)	Duration of Activity	Quality of Activity	Behaviors Noted during Activity
12:00 AM				
1:00 AM				
2:00 AM				
3:00 AM				
4:00 AM				
5:00 AM				
6:00 AM				
7:00 AM				
8:00 AM				
9:00 AM				
10:00 AM				
11:00 AM				
12:30 PM				
1:00 PM				
2:00 PM				
3:00 PM				
4:00 PM				
5:00 PM				
6:00 PM				
7:00 PM				
8:00 PM				
9:00 PM				
10:00 PM				
11:00 PM				