Hendricks Regional Health

Hendricks Regional Health
Physical & Occupational Therapy
Patient/ Caregiver Questionnaire

Pediatric Questionnaire

Please complete ***all pages*** of the following questionnaire, as this will assist your therapist in evaluating you. Should you need assistance, please ask the office staff. If you do not fill out this questionnaire, the therapist will have to spend your evaluation time completing it with you. ***Thank you!***

Child's Name _____ Date _____

Child's Date of Birth _____

o R o L hand dominant Age: _____ Height: _____ Weight: _____ Grade: _____

History:

Was your child born prematurely? _____ If so, how many weeks? _____

Please describe any complications during your pregnancy or child's birth_____
_____

For what reason are you bringing your child to therapy at this time_____
_____

Has your child ever had therapy before (how long/when/type of therapy/where)_____
_____

Who noticed your child had difficulties? ☐ Parents ☐ Physician When?_____

Please list your child's strengths or areas of recent improvement (what makes you smile?)_____
_____

Please indicate which developmental skills are areas of concern for your child. Please provide any comments regarding details of your child's difficulty or your observations of your child's skills in these areas.

Sitting	_____	Bathing	_____
Standing	_____	Eating	_____
Crawling	_____	Dressing	_____
Walking	_____	Using toilet	_____
Sleeping	_____	Writing	_____
Stair climbing	_____	Vision	_____
Motor Skills	_____	Social Skills	_____
Hearing	_____	Attention	_____
Speech	_____	Other	_____

Please circle/list specific activities that are hard because of the above difficulties (what makes you cry?): Circle one or add any others: Eating time School Travel Playing with you Playing with peers Shopping Vacations Sports _____

Other Comments:_____
_____

Therapist Use Only: _____
_____
_____

_____ _____

History reviewed by Therapist **Date**

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Additional History:

1. Check any previous treatments for this problem:

☐ Physical Therapy	☐ Social Service	☐ Support Group
☐ Dietary Consult	☐ Speech Therapy	☐ First Steps
☐ Occupational Therapy	☐ Splinting	☐ Surgery (date) _____
☐ Chiropractic	☐ Injection	☐ Other _____

2. Any X-rays, MRI, CT, EMG, etc. taken related to your child's current problem? ☐ yes ☐ no
   If yes, results (include date and where taken) _____

3. Past History of **Injuries/Accidents** and Past **Surgical History**:

Year	Description	Year	Description
_____	_____	_____	_____
_____	_____	_____	_____

4. Other Medical: Has your child ever been diagnosed with any of the following conditions?

		Associated Medication
Developmental Delay	☐ No ☐ Yes, Date/Comment: _____	_____
Attention Deficit	☐ No ☐ Yes, Date/Comment: _____	_____
Autism	☐ No ☐ Yes, Date/Comment: _____	_____
Diabetes	☐ No ☐ Yes, Date/Comment: _____	_____
Vision problems	☐ No ☐ Yes, Date/Comment: _____	_____
Mental Retardation	☐ No ☐ Yes, Date/Comment: _____	_____
Stomach disorders	☐ No ☐ Yes, Date/Comment: _____	_____
Seizure Disorder	☐ No ☐ Yes, Date/Comment: _____	_____
Cancer	☐ No ☐ Yes, Date/Comment: _____	_____
Hearing Problems	☐ No ☐ Yes, Date/Comment: _____	_____
Epilepsy	☐ No ☐ Yes, Date/Comment: _____	_____
Neurological (i.e. Stroke, Cerebral Palsy)	☐ No ☐ Yes, Date/Comment: _____	_____
Depression	☐ No ☐ Yes, Date/Comment: _____	_____
Sensory Processing Dysfunction	☐ No ☐ Yes, Date/Comment: _____	_____
Other	☐ No ☐ Yes, Date/Comment: _____	_____
Heart Condition	☐ No ☐ Yes, Date/Comment: _____	_____
High Blood Pressure	☐ No ☐ Yes, Date/Comment: _____	_____
Chemical Dependency	☐ No ☐ Yes, Date/Comment: _____	_____
Lung Problems	☐ No ☐ Yes, Date/Comment: _____	_____
Hepatitis	☐ No ☐ Yes, Date/Comment: _____	_____

5. List any additional medications or alternative medicines your child is currently taking (over the counter & prescription):
   _____

6. Please list any allergies (including allergy to Latex):
   _____

7. Has your child ever reacted to the following when handling, or after eating, avocados, bananas, tropical fruit, pineapple, kiwi, nectarines, peaches, cherries, chestnuts, poinsettia plants, balloons, elastic bandages or rubber products? ☐ yes ☐ no

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8. Does your child have, or has he/she had in the past; eczema on your hands, unexplained anaphylaxis (acute extreme shortness of breath, cardiac arrest or shock-sudden drop of blood pressure), or did you have multiple surgical procedures during infancy? ☐ yes ☐ no

9. Have your child ever been on cortisone/prednisone? ☐ No ☐ Yes, when? _____ ____

10. Does your child drink caffeine? ☐ No ☐ Yes, how much?_____

11. Why did you choose this facility for your service? (**Check all that apply**)
☐ Reputation of Clinic ☐ Insurance Requirement ☐ My physician's recommendation
☐ Location ☐ Friends or family's recommendation ☐ Other: _____

12. I and my child desire to learn : (**Check all that apply**)
☐ exercises ☐ injury prevention Other:
☐ posture correction ☐ additional resources that may help me

13. I and my child prefer to learn in the following ways:
☐ demonstration ☐ verbal instruction ☐ video ☐ written material

14. Difficulty with writing (circle one) parent/child? ☐ yes ☐ no ☐ comment _____
Difficulty with reading (circle one) parent/child? ☐ yes ☐ no ☐ comment _____

15. My/my child's primary language is: ☐ English ☐ Spanish ☐ Other _____

16. When is your child's next doctor's appointment for this problem? _____

17. Did your doctor give your child any limitations regarding this problem? If yes, please list/explain: _____
_____

18. Is there any other information you feel might be helpful for the therapist to know before your evaluation? If yes, please explain: _____

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Therapist Comments: _____