ALL ABOARD PEDIATRIC THERAPY
Parent/Caregiver Questionnaire

Today's Date _____
Child's Name _____ DOB_____
Other persons living in the home:

Name	Age	Male/Female	Lives with Child?	Medical Problems

Diagnosis_____
_
Who referred you here?_____
Parent's primary concerns and goals for therapy_____
_
_____
_____
__
When was the problem(s) first noticed?_____
Has your child been seen by anyone else for these concerns (when and where)?_____
_____

MEDICAL HISTORY

Family history of developmental delays, autism, MR, mental illness, other genetic disorders (please specify):_____
Does your child have a history of:

____ear infections ____fever over 103 ____feeding/swallowing deficits
____Trach ____allergies ____behavioral problems
____meningitis ____seizures ____asthma
____chronic colds ____vision deficits ____hearing deficits
____PE tubes ____hospitalizations ____surgery
____Congenital defects ____heart problems ____reflux
____Other:_____
If yes, please explain_____
_____
_____
__
_____

_
_____
_____
__
_____
_

Please list any medications that your child is currently taking:

Medication	Reason for taking

Please list any known allergies:

_____

Was the pregnancy full term _____ #of weeks _____
Birth weight/length_____
____Vaginal delivery ____Planned C-Section ____Emergency C-Section
Complications during pregnancy/delivery?_____
Suction or ventilator required for child? _____
Length of time in hospital for child _____ For mother _____
Did the child have to go to the NICU and why? _____

Check all that apply/applied to your child as an infant:
__fussy __quiet __active __alert __enjoyed being held
__floppy __calm __babbled __an easy baby __poor sleep patterns
__irritable __spit up often __good sleep patterns

<u>MOTOR DEVELOPMENT</u>
Please list approximate age that your child accomplished the following:
_____rolled over _____ate table foods _____spoke first word
_____sat independently _____drank from a cup _____used combined words
_____stood independently _____fed self with spoon _____skipped
_____crawled independently _____dressed independently _____rode a bicycle
_____walked (no support) _____toiled trained (day)
_____climbed steps _____toilet trained (night)
_____ran with control _____wrote name

_____jumped **_____cut with scissors**

If age-appropriate, please describe your child's level of independence with self-care:
_____
_____
_____

SOCIAL AND SENSORY DEVELOPMENT

Does your child:

__Play appropriately with toys **__shy away from new activities**
__engage in odd behaviors **__like to crash into things**
__have difficulty concentrating **__dislike changes/transition**
__have behavior problems **__react to loud noises/bright lights**
__appear awkward or clumsy **__avoid eye contact**
__have sensitivities to textures (clothing,tags,bathing,foods) **__prefer certain types of clothing**
__use a pacifier (now or ever)
__interact with peers appropriately **__interact with adults appropriately**
__take turns **__seem impulsive**
__display aggression towards self/others **__get easily frustrated**
__seem lazy/lethargic **___have inappropriate fears/avoidances**
__have difficulty sitting still **_____use an augmentative communication device**

Concerns and other helpful information_____
_____
_____
_____
_____
_____
_____
_____

What foods does your child typically eat? _____
_____

Feeding problems/nutritional concerns?_____
_____
_____
__
_____
_

Person completing form_____ **Relationship to child** _____

Speech-Language

Please circle either 1 or 2 for the following:
(1) My child exhibits this skill as much as a typical child his/her age.
(2) My child exhibits this skill less than a typical child his/her age.

1. **(1) (2) Articulation (speech sounds, how well they are understood)**
2. **(1) (2) Expressive language skills (ability to express wants/needs)**
3. **(1) (2) Receptive language skills (how well your child understands)**
4. **(1) (2) Vocabulary**
5. **(1) (2) Reading**
6. **(1) (2) Writing**
7. **(1) (2) Understand/Use figurative language (sarcasm, idioms, etc.)**