A to Z Pediatric Therapy

2021 PARENT/CAREGIVER QUESTIONNAIRE

GENERAL INFORMATION **Date:** _____

Child's Name: _____ Age: _____

Date of Birth: _____ Sex: _____

Parent 1's Occupation: _____ Level of Education: _____

Parent 2's Occupation: _____ Level of Education: _____

PATIENT HISTORY

Why is your child here today?

_____

_____

When was the problem first noticed? _____

Is your child aware of the problem? Yes ☐ No ☐

If yes, how does your child feel about it? _____

_____

How would you describe your child? _____

_____

FAMILY INFORMATION

List all people in household:

Name	Age	Sex	Grade	Relation

Does anyone else in the family have speech, language, or hearing problems? Yes ☐ No ☐

If yes, please describe: _____

What languages does your child speak? _____

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HEALTH & MEDICAL HISTORY

Has your child ever been examined by any other professionals? Yes ☐ No ☐

	Doctor	Practice	Date	Diagnosis Given/Results Found
Neurologist				
ENT				
GI				
Developmental Pediatrician				
Pediatrician				

Is your child currently on any medications? Yes ☐ No ☐

Medication	Dosage	Frequency	Purpose

Please describe your child's general health. _____

_____

Please list any health conditions, surgeries, etc. that you consider significant/relevant: _____

_____

_____

Has your child had his/her tonsils and adenoids removed? Yes ☐ No ☐

Has your child had any ear trouble (earaches, infections)? Yes ☐ No ☐

How many? _____

Has hearing been tested? Yes ☐ No ☐

If yes, when? Results? _____

Has your child ever had (PE) tubes inserted? Yes ☐ No ☐

If yes, when? _____

Has your child had their vision tested? Yes ☐ No ☐

Has your child ever worn glasses? Yes ☐ No ☐

Does your child currently wear glasses? Yes ☐ No ☐

Does your child have dental problems? Yes ☐ No ☐

Has your child ever had a seizure(s)? Yes ☐ No ☐

If so, are these treated with medication? Yes ☐ No ☐

If yes, please list: _____

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Were there any noticeable changes in your child's general behavior or speech after a certain life event, illness, surgery, etc.? Yes ☐ No ☐

If so, explain: _____

_____

Does your child have any known **skin** allergies? Yes ☐ No ☐

Latex allergy? Yes ☐ No ☐

Does your child have any **food** allergies or is s/he on a restricted diet? If so, please explain:

_____

_____

_____

_____

BIRTH HISTORY

Is your child adopted? Yes ☐ No ☐

At what age? _____

Does your child know s/he is adopted? Yes ☐ No ☐

Were there any complications or illnesses that occurred during pregnancy? Yes ☐ No ☐

Was any medication taken during pregnancy? Yes ☐ No ☐

If yes, please list: _____

Weight at birth _____ Was s/he full-term? Yes ☐ No ☐

Type of Birth: Normal Induced

Forceps Caesarean

Premature (at ____ weeks)

Any specific problems/issues at birth? Yes ☐ No ☐

If yes, list: _____

How would you describe your child's 1st year? _____

_____

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DEVELOPMENTAL HISTORY

Were developmental milestones met on time? Yes ☐ No ☐

Which milestones were met on time?

- ☐ Sits unsupported
- ☐ Eats solid foods
- ☐ Crawls
- ☐ Stands alone
- ☐ Babble
- ☐ Say 1st word
- ☐ Walks
- ☐ Self-feeds
- ☐ Self-feeds
- ☐ Bladder/bowel trained
- ☐ Use 2 word combos
- ☐ Say Complete sentences

If milestones were delayed, please elaborate: _____

_____

Does your child show aversive reaction to touching certain objects or textures? (Check all that apply).

- ☐ on hands
- ☐ on mouth/lips
- ☐ on face
- ☐ toothbrush
- ☐ on feet
- ☐ on body
- ☐ inside mouth
- ☐ hair brush

When did teeth erupt? _____

Last visit to dentist? _____

Bruxism? Yes ☐ No ☐

Thumbsucking? Yes ☐ No ☐

Pacifier? Yes ☐ No ☐

If yes, please describe usage: _____

When did you discontinue pacifier usage? _____

SPEECH & LANGUAGE HISTORY

How does your child communicate? (check all that apply)

- ☐ Eye contact
- ☐ Gestures
- ☐ Jargon
- ☐ PECS symbols
- ☐ Words
- ☐ Sentences
- ☐ Writing
- ☐ Moves person/adult
- ☐ Vocalizations
- ☐ Sign Language
- ☐ AAC device
- ☐ Phrases
- ☐ Conversation
- ☐ Other: _____

What efforts does your child make to communicate his/her wants when not understood?

_____

Is your child's speech understandable to: ☐ family? ☐ friends? ☐ strangers?

Did speech learning ever seem to stop for a period? ☐ Yes ☐ No

If so, describe: _____

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Can your child follow directions? Yes ☐ No ☐ ☐ 1 step direction ☐ 2 steps ☐ 3 steps

Please rate your child's attention:	**Good**	**Fair**	**Poor**
Preferred tasks	☐	☐	☐
Non Preferred tasks	☐	☐	☐
Academic tasks	☐	☐	☐
During interactions with others	☐	☐	☐

What have you done to help your child's speech and language? _____

_____

FEEDING DEVELOPMENT/HISTORY

Were there any feeding problems in early life? Yes ☐ No ☐

If so, describe:_____

Are there any current eating problems? Yes ☐ No ☐

If so, describe: _____

Does s/he have difficulty chewing or swallowing? Yes ☐ No ☐

Does s/he drool? Yes ☐ No ☐

Is your child a picky eater? Yes ☐ No ☐

How many food items are in your child's diet? <5 ☐ 5-10 ☐ 10-20 ☐ 20+ ☐

What are your child's favorite foods? _____

_____

Is there anything your child refuses to eat? _____

Does your child use utensils? Yes ☐ No ☐

Do they feed themselves? Yes ☐ No ☐

If not, who feeds the child: _____

How does your child take in liquid? ☐ Syringe ☐ Bottle ☐ Nuby Cup ☐ Sippy cup ☐ Straw ☐ Cup

Additional Comments on Feeding: _____

_____

Are mealtimes difficult? Yes ☐ No ☐

Will s/he try new foods? Yes ☐ No ☐

Has your child ever had issues with: Reflux ☐ Constipation ☐

If yes, when? _____

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Intake as Infant (only applicable for children 5 and under)

Method (check all that apply): ☐ Breast

☐ Bottle (Type of bottle: _____)

☐ Nipple (Type of nipple: _____)

Position of infant for feeding: _____

Average intake per feeding: _____ ounces in _____ minutes

Average intake per day: _____

Type of formula: _____

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EDUCATIONAL HISTORY

Child's current school: _____

Please list all previous schools and years attended: _____

_____

Current grade: _____

Has your child repeated a grade? Yes No

If yes, which grade? _____

Indicate performance level in school: ☐ Below Average ☐ Average ☐ Above Average

Did child attend nursery school and/or pre-K? Yes ☐ No ☐

If yes, where? _____

Does your child like school? Yes ☐ No ☐

Does your child receive services through any of the following:

☐ EIP ☐ Tutoring

☐ IEP ☐ 504 plan

If yes, please list services and frequency: _____

THERAPY:

Please provide information on therapies your child currently receives.

Therapy	Frequency	Therapist Name/Practice
Speech		
Feeding		
Occupational		
Physical		
ABA		
Floor Time		
Music		
Nutrition		
Other		

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BEHAVIOR/SOCIAL:

Does your child play: ☐ alone ☐ with older children
☐ with peers ☐ with younger children

Does your child have close friends? Yes ☐ No ☐

What are your child's most frequent discipline problems? _____

_____

Who handles discipline? _____

How is the child disciplined? _____

Please list your child's strengths when interacting with peers: _____

_____

Please list concerns you have about your child's interactions with peers: _____

_____

OTHER COMMENTS:

_____

_____

_____

_____

_____

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