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
❒ Seizures
❒ Intraventricular Hemorrhage (IVH) Grade_____
❒ Reflux/Gastroesophageal Reflux Disease (GERD)
❒ Periventricular Leukomalacia (PVL)
❒ Additional Diagnoses: _____
❒ Difficulty Feeding
❒ Physical/Occupational Therapy
❒ Speech Therapy
❒ 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)

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

Behavior

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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				