

## Georgetown University Hospital

### 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.***

Form completed by: \_\_\_\_\_ Date completed: \_\_\_\_\_

**Child's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_

**Address:** \_\_\_\_\_

Main language used at home: \_\_\_\_\_ other languages used: \_\_\_\_\_

How were you referred to our facility?  Dr. \_\_\_\_\_  Insurance Referral  
 Other: \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

#### **Family History**

Please list your child's caregiver(s):

Name	Relationship to Child	Contact Numbers	Occupation
		Home: _____ Cell: _____ Work: _____	
		Home: _____ Cell: _____ Work: _____	
		Home: _____ Cell: _____ Work: _____	
		Home: _____ Cell: _____ Work: _____	

Siblings/Other children in the home:

Name	Age	Grade in School	Developmental Delays?

#### **Medical History**

Biological Child  Adoption  Foster care

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: \_\_\_\_\_
- Premature  Post mature (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  Difficulty Feeding
- Oxygen tube  Physical/Occupational Therapy
- Retinopathy of Prematurity  Speech Therapy
- Seizures
- Intraventricular Hemorrhage (IVH) Grade \_\_\_\_\_
- Reflux/Gastroesophageal Reflux Disease (GERD)
- Periventricular Leukomalacia (PVL)
- Hearing Test Results:  Pass  Fail

Current Medical Status

**Referring Physician:** Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Please tell us any **other doctors or specialists** involved in your child's care:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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

Diagnosis	Age Diagnosed

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

Medication	Purpose

Does your child wear glasses or have problems seeing? \_\_\_\_\_  
 Results of last **hearing** evaluation: \_\_\_\_\_ Date: \_\_\_\_\_  
 Results of last **vision** evaluation: \_\_\_\_\_ Date: \_\_\_\_\_

Please list any additional hospitalizations since birth:

Age at Hospitalization	Reason	Length of Stay

Has your child had any special tests or procedures? (e.g. MRI, EEG):

Date	Procedure

Has your child been previously evaluated or treated by an occupational therapist, physical therapist, or speech language pathologist? \_\_\_\_\_  
\_\_\_\_\_

### **Development**

Please write the **age** when your child first performed the following skills:

Sat alone: \_\_\_\_\_ Toilet-trained: \_\_\_\_\_  
Crawled: \_\_\_\_\_ Learned to Write: \_\_\_\_\_  
Walked: \_\_\_\_\_ Said a single word: \_\_\_\_\_  
Babbled: \_\_\_\_\_ Dressed Him/Herself: \_\_\_\_\_  
Used a cup: \_\_\_\_\_ Fed His/Herself: \_\_\_\_\_

Does your child use any special equipment at home or at school?

- Walker       Wheelchair       Special cups/spoons  
 Assistive Technology       Other: \_\_\_\_\_

Equipment used in the home:

- Infant "walker" or jumper       Infant Swing       Exersaucer       Sippy cup

### **Speech and Language**

Please list any speech/language difficulties: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

### **Feeding**

Please list any problems with eating: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has your child had a swallow study given by a speech pathologist? \_\_\_\_\_

**School**

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Teacher(s): \_\_\_\_\_

Support Services:

- |  |   |
|--|---|
| <input type="checkbox"/> Individual Family Service Plan (IFSP) | <input type="checkbox"/> Occupational therapy |
| <input type="checkbox"/> Individual Education Plan (IEP)       | <input type="checkbox"/> Assistive technology |
| <input type="checkbox"/> Adapted PE                            | <input type="checkbox"/> Speech therapy       |
| <input type="checkbox"/> Physical therapy                      | <input type="checkbox"/> Classroom aide       |
| <input type="checkbox"/> 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 relate with brothers and sisters?  Poor  Fair  Well  n/a

How does child relate with children his/her own age?  Poor  Fair  Well

Does your child have any behavior problems? \_\_\_\_\_

Does your child have any attention problems? \_\_\_\_\_

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: \_\_\_\_\_

Does your child repeat or echo certain words or phrases? \_\_\_\_\_

Please add any other things we should know: \_\_\_\_\_

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UPON REVIEW OF HISTORY:

Therapist's Signature: \_\_\_\_\_

Date: \_\_\_\_\_