Clough Family Center for Rehabilitative and Sport Therapies

Pediatric Health Questionnaire

Welcome to Emerson Hospital's outpatient services! Please fill this form to the best of your ability, thank you.

SECTION 1 (Medical and Social History)

Please list reason(s) you are seeking therapy for your child:

_____

_____

_____

Patient Information

Child's name: _____
Date of birth: _____
Caregivers'/parents' names: _____
Siblings (ages)/ other people in the home: _____
Who referred your child for an evaluation (pediatrician etc.)? _____
Are you being hurt or made to feel afraid? ☐Yes ☐No

Family History

Please list family history (example: genetic disorder, scoliosis, auto-immune diseases, ADHD/ADD, sensory processing difficulties, hearing loss, speech/language/learning disabilities): _____

_____

_____

Languages:

Child's primary language: _____
Are there languages other than English spoken at home/school? ☐Yes ☐No
If yes, which language(s): _____
Name of school: _____
Would you like an interpreter? ☐Yes ☐No If yes, which language: _____

Educational and Social History

- Does your child attend daycare or school: ☐Yes ☐No If yes, what grade? _____
- Does your child have an IEP (Individual Education Plan) and receive services at their school? ☐Yes ☐No ☐ Did not qualify
  If yes, what services do they receive through the IEP: _____
- If no, did your child have an IEP in the past? ☐Yes ☐No

Medical History

Name of pediatrician: _____
Date of last visit with pediatrician: _____
Reason for Visit: _____

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Does your child see other doctors/specialists (ex: neurology, GI, orthopedics)? ☐Yes ☐No

- If yes, please list specialty and name of doctor(s)_____

_____

Any history of serious illnesses, diseases, broken bones, or surgeries? ☐Yes ☐No

- If yes, list date and type_____

_____

Any history of Seizures? ☐Yes ☐No If yes, list type and medications (if any)_____

_____

Allergies (if any):_____

Last Weight/Date: _____ Percentile: _____

Please check all that apply to your child (past/present):

☐Congenital heart defect	☐Cerebral Palsy	☐Cleft lip/palate
☐Respiratory problems	☐Down Syndrome	☐Traumatic brain injury
☐Impaired hearing/vision	☐Autism	☐Concussion
☐Learning disability	☐ Low or high muscle tone	☐Nerve injury or damage
☐ADD/ADHD	☐Difficulty swallowing/chewing	☐Scoliosis
☐Spasticity	☐Mental illness	☐Tongue tie
☐Cleft lip/palate	☐Reflux/GERD/Other GI disorders	☐Other genetic disorder
☐Upper Respiratory Infections (pneumonia, bronchiolitis)	☐Other, please explain:	

Adaptive Equipment

Does your child have or need adaptive equipment (wheelchair, utensils, communication device, etc)?

☐Yes ☐No If yes, please explain:_____

_____

Activities

Please list activities your child enjoys: _____

SECTION 2 (Developmental History)

Pregnancy and Birth History

Length of pregnancy (weeks):_____

Any complications for mother or baby during pregnancy? ☐Yes ☐No

If yes, please explain: _____

Type of Delivery (example: vaginal, C-section, vacuum assist):_____

Any complications during delivery (need for oxygen, low APGAR scores etc.)? ☐Yes ☐No

If yes, please explain: _____

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NICU stay? ☐Yes ☐No If yes please explain: _____
Birth weight: _____

Any concerns with your child's weight gain or growth? ☐Yes ☐No
Failure to thrive? ☐Yes ☐No

Does/did your child have any of the following:
Torticollis? ☐Yes ☐No Reflux? ☐Yes ☐No

Developmental History
Please list services your child is receiving or has received in the past (example: Early Intervention): ____
_____

To the best of your ability list the age your child did the following:
Rolling:_____Crawling:_____First Word:_____
Sitting:_____Walking:_____Combine 2 words:_____
Do you feel your child met most milestones on time? _____
Any concerns with regression in any areas (speech/language, gross motor skills)? ☐Yes ☐No
If yes please explain: _____

SECTION 3: (Hearing/Communication)
How many ear infections has your child had? _____
Has your child had tubes placed in their ears? ☐Yes ☐No If yes when? _____
Date of last hearing exam/screen: _____ Who did the hearing test?_____
Results: ☐ passed ☐failed ☐ other: _____
Has your child received a formal diagnosis by a medical professional? (e.g Learning Disability Autism Spectrum Disorder, Down Syndrome, etc.) ☐Yes ☐No If yes, when?_____
What is your child's primary means of communication (e.g. physical manipulation, gestures, sign, speech generating device, words)?_____

Do you have concerns about your child's communication and/or social skills? ☐Yes ☐No
If yes, please explain: _____
_____

What communication goals do you have for your child? _____
_____
_____

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SECTION 4 (Sensory Motor Skills)

Please check all that apply:

- ☐ Frequently trips on his/her own feet
- ☐ Walks on his/her toes
- ☐ Frequently bumps into furniture, walls, or other people
- ☐ Unaware of being touched or bumped uncles does with extreme force
- ☐ Unaware that face or hands are dirty (example: runny nose, food on face)
- ☐ Seems unsure of how to move his/her body, clumsy / awkward
- ☐ Slumps or slouches when sitting
- ☐ Has difficulty learning new motor tasks
- ☐ Is in constant motion, difficulty sitting still
- ☐ Chews on pends, straws, shirts, etc.
- ☐ Frequently touches people and objects
- ☐ Is overly sensitive to touch, noise, smells, etc.
- ☐ Avoids touching certain textures, please list: _____
- ☐ Avoids mess play (example: finger paints, mud, sand)
- ☐ Only eats certain foods or food textures, please list: _____
- ☐ Sensitive to clothing tags or textures
- ☐ Does not like hair brushed or teeth brushed
- ☐ Does not like to have fingernails trimmed
- ☐ Refuses to walk barefoot
- ☐ Gets "stuck" on toy or task, difficulty changing to another task
- ☐ Fearful of swings, slides, playground structures
- ☐ Fearless on playground equipment

SECTION 5 (Feeding)

EARLY FEEDING HISTORY

Any concerns with dehydration (past/present) ☐Yes ☐No If yes, please explain:_____

Any concerns with constipation (past/present) ☐Yes ☐No If yes, please explain:_____

Any concerns with sleep (past/present) ☐Yes ☐No If yes, please explain:_____

Was your child breast-fed? ☐ Yes ☐ No If yes, please explain: _____

Did your child latch easily for breastfeeding? ☐ Yes ☐ No If yes, please explain:_____

Was your child bottle fed? ☐ Yes ☐ No If yes, please explain:_____

History of dependence on supplemental nutrition? ☐ Yes ☐ No If yes, please explain:_____

☐G-tube ☐ NG-tube ☐Pediasure ☐Other: _____

Did your child use a pacifier? ☐ Yes ☐ No If yes, for how long? _____

Did your child mouth toys as an infant? ☐ Yes ☐ No

When did you introduce solid foods? _____

What were the first foods? _____

Any problems with solid food introduction? ☐ Yes ☐ No If yes, please explain:_____

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Any problems with (current or past):
Straw drinking? ☐ Yes ☐ No If yes, please explain:_____
Open cup drinking? ☐ Yes ☐ No If yes, please explain:_____
Spoon Feeding? ☐ Yes ☐ No If yes, please explain:_____
Chewing? ☐ Yes ☐ No If yes, please explain:_____

History of (check all that apply):
☐Coughing/choking during or after drinking ☐Gagging/vomiting during/after drinking
☐Wet vocal quality during or after drinking ☐Pain or discomfort during/after drinking
Details:_____

History of (check all that apply):
☐MBS ☐ Feeding team evaluation ☐FEES ☐Upper GI ☐Other:_____
Dates of evaluations:_____
Results:_____
Comments:_____

CURRENT FEEDING STATUS
Briefly, what are your concerns regarding your child's feeding development/skills?_____
_____
When did you first become concerned about your child's eating?_____
What made you concerned?_____
How is your child currently being fed (check all that apply)?
☐G-tube ☐ NG-tube ☐J tube ☐NJ tube ☐Mouth

Bolus Schedule:_____
Does your child show signs of hunger? ☐ Yes ☐ No
How does your child let you know he/she is hungry?_____
Length of typical mealtime?_____
Feeding environment: ☐high chair ☐table ☐walk around ☐other:_____
Are feeding times stressful? ☐ Yes ☐ No ☐Sometimes, Comments:_____

Currently drinks from (check all that apply):
☐bottle ☐breast ☐sippy cup ☐straw ☐open cup

Currently eats with (check all that apply): ☐spoon fed ☐hands ☐utensils ☐pouches

Does your child currently:
☐gag during/after feeding ☐frequently cough during/after feeding
☐food out of nose during or after eating ☐choke during feeding
☐vomit during/after eating ☐have a wet vocal quality during/after feeding

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Please describe any other behaviors that are of concern (check all that may apply):

☐overstuffing mouth with food	☐refuses to eat	☐frequently drools
☐spills foods/drinks from mouth	☐does not chew foods	☐mouths objects/fingers
☐difficulties using cup and/or straw	☐pockets food in mouth	☐strong food preferences
☐avoids specific food textures/groups	☐messy eater	☐avoids face washing
☐strong temperature preferences	☐picky eater	☐avoids being messy
☐strong flavor preferences	☐throws food	☐refuses new foods
☐visible pain or discomfort while swallowing	☐spits out food	☐grazes through the day

Historically, child consumes adequate amount and variety of:

Liquids ☐ Yes ☐ No
Fruits ☐ Yes ☐ No
Vegetables ☐ Yes ☐ No
Grains ☐ Yes ☐ No
Dairy ☐ Yes ☐ No
Meats ☐ Yes ☐ No

What does your child eat on a "typical" day? *List specific foods and times*
Morning:_____
Noon:_____
Evening:_____
Overnight:_____
Please report cultural/religious preferences related to feeding:_____
_____