PERSONAL INFORMATION

Child's Preferred Name: 

KEY QUESTIONS ABOUT YOUR CHILD’S CONDITION AND HISTORY

Who referred/recommended your child for therapy?  □ Physician  □ Self  □ School  □ Other  

Reason for referral:  

Next scheduled Dr. appointment(s):  

Date:  

Physician:  

Date:  

Physician:  

When did your child's problem occur or become worse?  _____ / _____ / _________

Has your child ever been evaluated for or attended therapy for:

□ Speech problems  □ Vision problems  □ Feeding problems  □ Hearing loss  

□ Physical motor problems  □ Fine motor problems  □ Sensory Problems  

□ Cognitive concerns  Who, Where & When?  

Do you suspect your child has a hearing loss?  □ Yes  □ No  

Does your child wear Hearing Aids?  □ Yes  □ No  

If "Yes", what behaviors lead you to suspect this?  

Do you suspect your child has a hearing loss?  □ Yes  □ No  

Does your child wear glasses?  □ Yes  □ No  

Use any of the following equipment?  □ Braces  □ Walker  □ Wheelchair  □ Other:  

Recent illnesses, injuries or hospitalizations?  □ Yes  □ No  

If "Yes", please explain:  

Has your child had any surgical or invasive procedures?  □ Yes  □ No  

If "Yes", please list:  

Does your child have any allergies (e.g. adhesives, latex, cortisone)?  □ Yes  □ No  

If "Yes", please list with any reactions/treatments  

Is your child's immunization/vaccination status current?  □ Yes  □ No  

What is your child's height:  

weight:  

MercyOne Rehabilitation Services  
Pediatric History Questionnaire
Is your child taking any medications?  ☐ Yes  ☐ No  If "Yes", please list:
__________________________________________________________________________
__________________________________________________________________________

Is your child taking any over the counter medications or herbal preparations?  ☐ Yes  ☐ No  If "Yes", please list:
__________________________________________________________________________
__________________________________________________________________________

List any frequently occurring medical problems your child has:
__________________________________________________________________________

PRENATAL and BIRTH

During Pregnancy (check all that apply):  ☐ Excessive vomiting  ☐ RH incompatibility  ☐ Drug use  ☐ Alcohol use  ☐ Hemorrhaging  ☐ Medications  ☐ Smoking  ☐ Illnesses  ☐ Trauma or injuries  ☐ X-Ray treatments  ☐ High blood pressure  ☐ Other

Labor and Delivery (Weight & check all that apply):  Birth weight: ____________  ☐ Full term  ☐ Premature _______ weeks early  ☐ Normal delivery  ☐ Induced labor  ☐ Forceps  ☐ Prolonged labor  ☐ Breeched presentation  ☐ Cesarian

Conditions After Birth (check all that apply):  ☐ Difficulty breathing  ☐ Difficulty sucking  ☐ Difficulty feeding  ☐ Seizures  ☐ Birth defect  ☐ Extended hospital stay  ☐ Jaundice  ☐ Infections

Medical History (check all that apply):  ☐ Ear infection  ☐ Tube inserted  ☐ Head injury  ☐ Asthma  ☐ Encephalitis  ☐ Meningitis  ☐ Seizures  ☐ Genetic disorder (please list)  __________________________  Other:  __________________________

DEVELOPMENT

Which of the following do you think your child understands:

☐ His/her own name  ☐ Names of body parts  ☐ Family names  
☐ Names of objects  ☐ Simple directions  ☐ Complex/multiple step directions  
☐ Conversational speech

Play Behaviors:  My child prefers playing  ☐ by himself/herself  ☐ with other children

What is the average length of time your child can stay playing at one activity?  __________________________

What activities seem to hold your child's attention for the longest period of time?  __________________________

Shortest period of time?  __________________________

Social / Emotional Behaviors (check all behaviors that best describe your child):

☐ Overly shy  ☐ Overly active  ☐ Excessive tantrums  ☐ Difficulty with change in routine  
☐ Destructive  ☐ Very shy  ☐ Controlling  ☐ Easily overwhelmed in busy environment  
☐ Friendly/outgoing  ☐ Imaginative  ☐ Perfectionist  ☐ Overly sensitive to noise/loud sounds  
☐ Difficulty separating from parent  ☐ Rigid  ☐ Plays well with other children  ☐ Poor eye contact  
☐ Sedentary  ☐ Resistant to self care

Motor Development:  At approximately what age did your child achieve the following motor milestones?

_________ Sitting alone  __________ Crawling  __________ Standing alone  _______ Walking alone

_________ Self finger feed  _______ Eating with spoon  _______ Hold bottle  _______ Potty trained

_________ Rolling  _______ Hold head up  _______ Reaching for toys
Speech and Language Development: (Speech Therapy referrals only, physical / occupational therapy proceed to educational history)
Indicate at what age your child first demonstrated the following

- Babbling
- Jargon (talking own language)
- Single words
- Phrases
- Short sentences

What is the primary method your child uses for letting you know what he/she wants?

- Looking at objects
- Pointing at objects
- Gestures
- Crying
- Vocalizing
- Physical manipulation
- Single word
- 2-3 word combinations
- Sentences

Which of the following statements best describes your child's speech (select one):

- Easy to understand
- Almost never understood by others
- Difficult for mother to understand
- Different than other children of the same age
- Difficult for others to understand

Which of the following statements best describes your child's reaction to his/her speech (select one):

- Is easily frustrated when not understood
- Does not seem aware of speech/communication problem
- Has been teased about his/her speech
- Tries to say sounds or words more clearly when asked
- Is successful in saying sounds or words more clearly when he/she tries

Does your child have difficulty pronouncing certain sounds? 
- Yes
- No

If "Yes" which ones?

How do family members react to his/her speech problem?

What is your child's awareness of / reaction to his/her speech problem?

Educational History:
Does your child attend:
- Preschool
- Day Care
- Public School
- Private School
- Grade:

List any special education services your child receives at school:

FAMILY HISTORY
Mother: 
Age:
Occupation:

Marital Status: 
- Single
- Married
- Separated
- Divorced
- Widowed

Were there any miscarriages? 
- Yes
- No

History of developmental or speech/language problems? 
- Yes
- No

If "Yes" please explain:

Father: 
Age:
Occupation:

Marital Status: 
- Single
- Married
- Separated
- Divorced
- Widowed

History of developmental or speech/language problems? 
- Yes
- No

If "Yes" please explain:
Brothers/Sisters:

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<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Developmental and/or Speech Problems</th>
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Is there a family history of any of the following?  □ Hearing loss  □ Speech problem  □ Learning Disability  □ Cleft Palate  □ Seizure Disorder  □ Alcoholism  □ Autism  □ Genetic Disorders (please list) ____________________________________________  
Who? ____________________________________________

Who is currently living in the house with your child? (check all that apply):  □ Biological Mother  □ Biological Father  □ Adoptive Parent  □ Unmarried Partner  □ Sister(s)  □ Brother(s)  □ Other (please specify) ____________________________________________

Is your child or any other household member experiencing any physical abuse?  □ Yes  □ No

Is any language other than English spoken in the home?  □ Yes  □ No
If "Yes", what is the primary language spoken? ____________________________________________

Have there been any major changes in the family during the past year?  (i.e. change of address, parent separation or divorce, accident, illness, death, birth, etc)?  □ No  □ Yes ____________________________________________

Will your child have any problem attending therapy sessions:  □ Yes  □ No  If "Yes", please describe: ____________________________________________

PERSONAL GOALS FOR THERAPY

What do you want your child to achieve from having therapy? ____________________________________________

Please include any additional information you feel would help us provide your care (i.e. what you think would help, any apprehensions about treatment, special communication, language, spiritual, or cultural needs). ____________________________________________

To the best of my knowledge, the above information is complete and factual.

Signature of person completing this form ___________________________  Date ___________________________

Relationship to client (child) ____________________________________________