703-910-5006 www.CreativeHealthLLC.com INFO@CreativeHealthLLC.com

Pediatric Initial Consultation Questionnaire

Client's Name:_____ Gender:____ Today's Date:____/____/____

Date of Birth: ____/____/_____ Age:_____yrs.____mos. Grade:_____

Referred by:_____

Parent's Name(s):_____

Address(s):_____

_____

Telephone (circle preferred): Cell_____ Home _____

Work _____ Fax#_____

Email:_____

Name of person completing this form:_____

Relationship to child:_____

MEDICAL HISTORY

Primary Care Physician _____Specialty_____

Practice name:_____

Address:_____

Phone _____ Fax _____ Email _____

Current medications and/or remedies prescribed:

1)_____ Start Date ____/____/_____ Purpose_____

_____

2)_____ Start Date ____/____/_____ Purpose_____

_____

3)_____ Start Date ____/____/_____ Purpose_____

_____

4)_____ Start Date ____/____/_____ Purpose_____

_____

Prescribed by:_____

Has your child ever been hospitalized? (Circle one) YES NO

Age Reason

_____ _____

_____ _____

_____ _____

Does your child currently have any medical diagnoses? YES NO

If so, please specify: _____

When was it determined?_____

By whom?_____

_____

Was mother's condition during pregnancy good to excellent? YES NO

Were medications taken during pregnancy? YES NO If yes, what? _____

_____

Were there any complications/illnesses during pregnancy? YES NO

Was your child born within two weeks of the due date? YES NO

Was your child adopted? YES NO

Were labor and delivery normal? YES NO

Was there evidence of injury or poor health at birth? YES NO

Was your child's health during the first month of life good? YES NO

As an infant, did your child seem.... (check those that apply)

.....happy? .....to cry frequently?

.....to sleep long hours? .....to wake often? .....difficult to get to sleep?

.....to like being rocked? .....to like being held? .....difficult to soothe?

FEEDING HISTORY

Was your child (circle one or both) breast or bottle fed?

During what ages? Breast_____ Bottle_____

Describe what was successful about how your infant fed:_____

_____

_____

Were there any feeding problems during infancy or as a toddler? YES NO

If so, please describe: _____

_____

_____

During feeding of your infant, did any of the following occur? If so, describe:

Arching:_____

Cough:_____

Cry:_____

Gag:_____

Pull at the nipple:_____

Spit up:_____

Vomit:_____

Describe how weaning went, including issues:_____

_____

_____

Age of introduction of baby cereal _____ baby food _____ finger food _____ table food _____

At what age did your child fully transition to table food: _____

Describe any food introduction or transition issues: _____

_____

_____

Check any of the following that are <u>currently</u> occurring with your child:

_____categorically avoiding foods because of certain textures or types

_____choking, coughing, gagging when eating _____nasal reflux _____vomiting

_____difficulty coordinating breathing and swallowing _____eats fewer than 20 foods

_____ picky eating _____meals are battles _____poor weight gain

Please comment on any of the above areas that you checked: _____

_____

_____

Does your child have allergies or are allergies suspected? YES NO

Did your child's teeth develop normally? YES NO

MEDICAL HISTORY

Describe any important medical history, chronic ailments, or other health problems that your child has experienced, not listed above: _____

_____

_____

_____

Does your child have any close relatives (father, mother, sister, brother, grandparent) who have similar medical histories? Please list:_____

_____

_____

_____

_____

Please list any other specialists that your child has been seen by for medical, developmental or educational concerns. Please note those that are currently being seen.

_____

_____

_____

_____

Does your child receive Speech/Language Therapy Services? YES NO

If yes, how often?_____For how long?_____

Does your child receive Physical Therapy Services? YES NO

If yes, how often?_____For how long?_____

Does your child receive Occupational Therapy Services? YES NO

If yes, how often?_____For how long?_____

FAMILY

Describe your relationship with your child, currently and in the past:

_____

_____

_____

_____

_____

_____

Describe your child's relationship with her/his other parent or primary caregiver:

_____

_____

_____

List names and ages of your child's brothers & sisters:

Name	Age	Relationship (biological, step, half, etc)	Lives with?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Any others living in the home with your child?

Name	Age	Relationship	Grade/Occupation
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Other than those already mentioned, who is in your child's support network?

_____

SCHOOL HISTORY

School:_____Class Size and Type_____

Teacher:_____Supports:_____

Extra-curricular:_____

Does your child experience any developmental, academic or behavior problems while in school or daycare, with peers or teachers? (Circle one) YES NO If yes, please explain:

_____

_____

_____

Is/was your child home-schooled? (Circle one) YES NO. How many years?_____

DEVELOPMENTAL HISTORY

Has your child achieved any of the following sensory-motor milestones? Please state the age if achieved and any comments regarding the quality of their performance.

Milestone *Age/Comments*

Crawling _____

Come to sit alone _____

Walking _____

Using a cup _____

Using a spoon _____

Chew solid food _____

Using crayons _____

Using a toilet _____

At what age did your child:

Speak first words:_____Examples:_____

Two-word phrases:_____ Examples:_____

Three-word phrases:_____ Examples:_____

How does your child communicate now? (words, sounds, gestures, pointing)

_____

_____

Does your child understand or speak another language besides English? ____

If so, what languages: _____

How many words can your child say?__1-10 __10-50__50-100__100-300 __300-500

Give a few examples of your child's speech_____

_____

_____

Do you think your child has a hearing problem?____If so, describe_____

_____

_____

Has your child's hearing been tested?___If so, where_____
Findings?_____

Describe how your child performs and/or feels about performing the following tasks:
Putting on or taking off clothing:_____
_____
_____
Using arts and craft supplies:_____
_____
_____
Learning new movements:_____
_____
_____
Opening containers:_____
_____
_____
Independence with feeding:_____
_____
_____
Being asked to transition to another activity:_____
_____
_____
Adjusting to changes:_____
_____
_____
Writing:_____
_____
_____
Reading:_____
_____
_____

Listening to music:_____

_____

_____

Singing:_____

_____

_____

If your child exhibits any behavior below, provide age range; describe attempts to alter it.

Behavior *Age range/Attempts to alter*

Excessive shyness_____

Thumb/pacifier sucking_____

Difficulty separating from parents_____

Face twitching_____

Strong fears/nightmares_____

Temper tantrums_____

Sleep difficulties or bed wetting_____

Difficulty sitting still_____

Inability to complete activities_____

Attention problems_____

Non-compliance with routine activities_____

NEURO-PHYSIOLOGICAL STATUS

Please check any of the following disturbances that describe how you believe your child has been feeling lately:

_____sad _____anxious _____depressed _____frightened _____guilty _____angry

_____ashamed _____aggressive _____resentful _____worthless _____tearful _____irritable

_____confused _____extreme ups/downs _____jealous _____hopeless

_____

_____

_____

_____

_____

_____

Describe any problems which have occurred in your child's life related to trauma, stress and/or abuse:_____

_____

_____

_____

What are your child's sleeping habits like? Include any recent changes.

_____

_____

_____

_____

What makes your child laugh?_____

_____

_____

_____

What does your child do when angry, frustrated, or overwhelmed?

_____

_____

_____

_____

How does your child calm him/herself down?_____

_____

_____

_____

_____

Please, briefly, describe any issues or sensitivities your child may have that involve:

Hearing: _____

_____

_____

_____

_____

Touch: _____

_____

_____

_____

_____

Smelling: _____

_____

_____

_____

_____

Mouthing/Eating: _____

_____

_____

_____

_____

Movement: _____

_____

_____

_____

Vision: _____

_____

_____

Has your child's vision been tested?____If so, where_____

Findings?_____

PLAY

What are your child's favorite toys, activities, or games?_____

_____

_____

_____

_____

How long does your child play at these favorite activities?_____

_____

_____

_____

_____

With whom does your child prefer to play?_____

_____

_____

_____

Does your child play well with other children?_____

_____

_____

_____

_____

How does your child play when left alone?_____

_____

_____

_____

LEVEL OF FUNCTIONING

Please list any accommodations, at home or at school, that your child currently uses to help with participation in daily activities. (visual schedules, sensory diet, equipment, etc.)

_____

_____

_____

_____

Please describe your child's level of physical activity:_____

_____

_____

_____

How much time every day does your child play on the computer_____, watch TV_____, or play video games_____?

TREATMENT PLANNING

What do you consider to be your child's greatest strengths?_____

_____

_____

What do you consider to be your child's greatest challenges?_____

_____

_____

Any other comments that might be helpful to us?_____

_____

_____

Please list your therapy goals for your child:_____

_____

_____

_____

_____

_____

_____

_____

Your Name_____ Date:____/____/_____

Please provide this information, along with copies of any previous evaluations, educational plans or other reports that you would like the therapists to consider when assessing and treating your child.

Thank you so much for taking the time and effort to fill out this lengthy form.

Judy D Feingold OTR/L

_____ Date:____/____/_____