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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:____

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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:__________________________

____

____

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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 currently 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

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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:

____

____

____

____

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____

____

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:

____

____

____

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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________________

____

____

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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:____

____

____

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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____

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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?

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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: ____

____

____

____

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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?_______________________________________

____

____

____

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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________?

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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:___/___/____

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