Patient Questionnaire

Date: _____

Patient Name: _____ DOB: _____

Person completing this form: _____ Relation: _____

Presenting Complaints:

1. In your own words, describe concerns and diagnosis regarding the patient.
   _____
   _____
2. When his/her problem was first noticed?
   _____
   _____
3. How his/her problem was first noticed?
   _____
   _____
4. What has been done about the problem? (If the patient has had previous examinations or therapy, please tell where, when, by whom and what recommendations or treatment was given)
   _____
   _____
5. What changes, if any, have you noticed in the patient's general condition recently?
   _____
   _____
6. Is the patient aware of these problems? _____ If yes, how do you know?
   _____

Please Check Your Areas of Concern:

Walk ____ Talk ____ See ____ Hear ____ Dress Self ____ Write/Print ____ Tell Time ____ Use Toilet ____ Feed Self ____ Use Telephone ____ Prepare Own Needs ____ Travel Alone ____ Bathe/Groom Self ____ Work Independently ____ Wash Clothes ____ Self-Medicating ____ Communicate ____ Recognizes money/make change ____

Medical History

1. Were there any irregularities during this pregnancy? (i.e., German Measles, Bleeding, Chicken Pox, False Labor, RH compatibility, Anemia, etc.)?
   _____
2. What medications, if any were used during this pregnancy?
   _____
3. What was the length of this pregnancy: _____ What was the duration of labor: _____
4. Type of delivery: ____ Normal ____Breech ____ Cesarean
5. Anesthetics used during delivery: _____
6. Birth Weight: _____
7. How old was the child when he/she left the hospital? _____
8. Did this child require any special attention while in the hospital? _____
9. City/State and Hospital where this child was born: _____
10. History of Illnesses **(Please indicate age at which the illness occurred):**
    Measles _____ Mumps _____ Whooping Cough _____ Ear Infection _____ Scarlett Fever _____
    Allergies (Specify) _____ High Fevers _____ Epilepsy _____ Influenza _____
    Tonsillitis _____ Convulsions _____ Sinusitis _____ Frequent Colds _____ Kidney Problems ____
    Visual Difficulties _____ Head Injuries _____ Other _____
11. Has this child ever been examined by a neurologist? _____
12. Has this child ever been hospitalized since birth? _____ If so, when and for what reason?
    _____

Speech and Language Development

1. Does your child have difficulty simple directions? _____
2. Are there words that your child appears to understand but cannot say, such as bye-bye, no, cookie, bath, etc. Please list if less than 10 words: _____
3. How does he/she know that he/she understands words/phrases? _____
4. Does your child attempt to mimic words of others? _____
5. At what age was this child when he/she said his/her first meaningful words? _____
   What was it? _____
6. Does your child communicate using words, sign language or gestures? _____
7. What best describes your child's present speech/language behavior: follows directions well ____ seems to understand what is being said to him/her ____ Appears to have difficulty hearing ____

Child Case History

____ Needs to look at the person speaking to understand

____ Seems to be unaware of sounds in the environment

____ Rarely attempts speech

____ Depends primarily on signs or gestures instead of speech

____ Attempts speech but is difficult to understand

____ Uses speech sounds incorrectly (omits/substitutes/distorts)

____ Leaves out words or confuses word order

____ Stammers or stutters

____ Talks too fast or too slows (circle one)

____ Uses an abnormal voice (hoarse/nasal/whispery)

____ Uses an abnormal pitch level (too high/too low)

____ Uses complete sentences

____ Uses only phrases

Behavioral Profile

1. Does patient have challenging behavior or temper tantrums? _____
2. Describe patient's typical behavior with regards to activity level: _____
   Aggressive or Passive:_____ Reaction to others: _____
3. Describe any unusual/extreme behavior of patient with regards to:
   Reaction to authority: _____
   Non-Compliant/Oppositional behaviors: _____
   Injurious episodes: _____
   Self-Stimulating behaviors: _____
   Will child separate willingly from parents for the purpose of therapy evaluation? _____

Fine Motor Development

1. Do you feel this child's fine motor corporation is appropriate for his/her age? _____
   If not, please explain: _____
2. Were there any feeding difficulties following birth (sucking, chewing, swallowing)? _____
   If yes, please example: _____
3. Is the child able to pick up small objects, such as wooden block or bead, and hold it in his/her hand? _____

Fine Motor Development

Check any and all statements, which most accurately describe this child's present fine motor skills:

____ Dislikes being helped or cuddled

____ Avoids getting hand in past, finger paint or other messy material

____ Is irritated by cloth or certain textures

____ Tends to examine objects by touching them thoroughly with hands

____ Spins or whirls more than most children

____ Hesitates to climb or play with equipment which might move him in a manner that makes him insecure

____ Went from sitting to standing without much crawling

____ Crept on tummy rather than on hands and knees

____ Learned to dress self on schedule

Gross Motor Development

1. Do you feel that this child's physical coordination is appropriate for his/her age? _____
   If not, please explain: _____
2. At approximately what age did this child sit alone? _____ Walk alone? _____
3. Is this child toilet trained? _____ At what age? _____
4. Has he/she remained completely trained since the above age? _____
5. Do you currently have any adaptive equipment such as AFO's, wheelchair, bolster seat or standers? _____
6. Do you feel your child needs adaptive equipment? _____
   If so, please explain: _____
7. Are there difficulties in transferring your child from room to room in your house? _____
   If so, please explain: _____
8. Do you have the need for home modification or changes? _____
   If so, please explain: _____

Personal Goals for Your Child

1. What skills would you like the therapist to address with your child? (Improve mobility, self-care skills, social skills, play skills, etc.)
   _____
   _____

2. Please list what you feel are your child's strengths:
   _____
   _____

3. Please list your child's interest/hobbies:
   _____
   _____