Pediatric Medical History Questionnaire

To better serve you and your child’s individual needs, please complete the following and check appropriate choices when indicated.

Child’s name (please print):

1. Main reason for needing therapy: ____________________________
   Date of injury or onset: _______/_____/_____

2. Birth History: (pregnancy related, complications with labor & delivery, APGARs after birth, need for oxygen)

3. Pediatrician:

4. Other physicians involved in your child’s care:

5. Has your child received therapy before? □ Yes □ No When?

6. Any previous surgeries or medical procedures? □ Yes □ No
   Date/Type: ____________________________

   Precautions:

   7. What tests have been done? □ X-ray □ MRI □ CT Scan □ Swallow Study □ EMG □ PET Scan □ Other:
      Findings: ____________________________

   8. Is your child able to sleep through the night? □ Yes □ No

   9. What is the frequency of your child’s bowel movements?

10. Developmental Milestones Achieved:
    Talking: □ Not age appropriate □ Age achieved: _______ □ Unsure
    Rolling: □ Not age appropriate □ Age achieved: _______ □ Unsure
    Sitting: □ Not age appropriate □ Age achieved: _______ □ Unsure
    Walking: □ Not age appropriate □ Age achieved: _______ □ Unsure

11. Child/Family Goals and Preferences: ____________________________

12. Child/Family Adjustment to Activity Limitations: ____________________________

13. Support Available (siblings, caregivers, peers, professional organizations):

14. Child’s favorite toys, songs, games:

15. Does your child have any fears or sensitivities? □ Yes □ No
    If yes, what are they?

16. School/Work Related Issues:
    School/Daycare Attending: ____________________________ Grade: _______

17. Does your family practice any cultural traditions that you would like us to be aware of?
    □ Yes □ No □ If yes, what are they?
    What is the primary language used in the home?

18. Please answer the following if your child is age appropriate.
    Is there a history of alcohol or drug abuse? □ Yes □ No □ Not age appropriate
    If yes, please explain: ____________________________

    Is your child sexually active? □ Yes □ No □ Not age appropriate
    If yes, please state any concerns: ____________________________
## Pediatric Medical History Questionnaire

### Allergy Information

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<thead>
<tr>
<th>Latex allergy?</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Other Allergies:</td>
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<td>Type of Reaction:</td>
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### Medication Information

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<th>Medication Name</th>
<th>Reason for Taking Medication</th>
<th>Prescribing Physician</th>
<th>Physician Phone Number</th>
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☐ See attached medication list, which includes the physician name and telephone number.

Child’s name  (please print)

Parent/Guardian name  (please print)

Parent/Guardian signature

Date

Time