NORTHERN IOWA THERAPY
Occupational, Physical, Speech Therapy

Pediatric History / Parent Questionnaire

Child's Name _____ **Date of Birth** _____ **Age** _____

What issues/areas are a concern for your child?_____

_____

MEDICAL HISTORY

Birth Weight _____Height _____ Duration of Pregnancy _____Type of Delivery: _____
Complications at Birth: _____

_____

Treatment Received by baby and/or mother as result of birth complications:

_____

Surgeries, medical procedures, hospitalizations, illness (including ear infections, tubes, tonsillectomy, etc) and ages these occurred:_____

_____

Child's previous therapy and specific evaluations performed? _____

_____

Date of last vision exam, results? _____
Date of last hearing evaluation, results?_____
Allergies (Food / Adhesive / Latex)?_____

_____

Current Medications □ NO □ YES if so what kind _____
History of seizures □ NO □ YES if so what kind _____
If so- precautions: _____
Orthotics or adaptive devices: _____

HOME INFORMATION

Languages spoken: _____
Siblings: _____
Parents: _____Marital Status (circle) Married Single Divorced
Living Arrangement (where): _____
Pets?_____
Any history of Abuse? _____
How does your child play/spend their day?_____

_____

Child's Likes/Dislikes:_____

_____

SCHOOL INFORMATION

What school does your child attend_____ Grade: _____
Does your child have an IEP? YES NO (If yes, Please bring in at your next appointment)
Does your child receive therapy in school? ☐ OT ☐ PT ☐ ST If yes, describe the reason for therapy:

_____

Areas of concerns at school? _____

DEVELOPMENTAL MILESTONES: at what age did your child do the following?

Roll back to stomach _____
Roll stomach to back _____
Sit unsupported _____
Sit supported _____
Pull to stand _____
Crawl _____
Cruise _____
Walk _____
Climb stairs_____
Run _____
Toilet train _____

Begin eating solid foods _____
Finger feed self _____
Use utensils _____
Drink from cup _____
Imitate sounds _____
Say 1st word _____
Say 2-word phrases _____
Follow simple directions _____

How did your child tolerate tummy time?_____

List any feeding difficulties/ picky eater: _____
_____
When did your child stop using a bottle?_____

Was your child breast or bottle fed? Any difficulties latching?_____

COMMUNICATION SKILLS
Describe your child's current **expressive language.** What sounds do you notice he/she has difficulty saying? Does he/she use more gestures (waving, pointing, hand-pulling) or words to communicate his/her wants? How many words does he/she put together in sentences? _____
_____
_____
Describe your child's current **receptive language.** Is he/she able to follow directions? Does he/she seem to understand age-appropriate vocabulary? Can he/she understand age-appropriate stories? _____
_____
_____

Describe your child's current **social communication** (pragmatics). Does he/she use greetings, appropriate eye contact and turn taking? Describe your child's ability to make friends and maintain friendships. _____
_____
_____
Describe your child's temperament/behavior (how he/she handles frustration, shyness, outbursts, etc.)
_____
_____

What are your goals and expectations for therapy? _____
_____
_____