PURE PEDIATRIC THERAPY

Pediatric Occupational, Physical, and Speech Therapy

Parent/Guardian Questionnaire

Please fill this out BEFORE your initial evaluation

Date: _____

Child's Name: _____ Date of Birth: _____

Name of person filling this out: _____ Relation to child: _____

Family History

Mother: _____ Age: _____ Occupation: _____

Father: _____ Age: _____ Occupation: _____

Siblings: (list name and age)_____

Birth History

☐Full-term ☐Premature, How many weeks _____ ☐Vaginal ☐Cesarean section

Mother's age at delivery: _____ Pregnancy/Delivery complications _____

Child's birth weight: _____ Birth length: _____ Apgars:_____

Was your child hospitalized after birth? If so, please describe why and for how long: _____

_____

Therapy Goals

Who referred you to Pure Pediatric Therapy?_____

Why are you seeking therapy services? Please describe your primary concern: _____

_____

What goals do you hope your child will achieve with therapy? _____

_____

Medical History

Is your child receiving vaccines timely? _____

Does your child currently have a medical diagnosis? If so, please elaborate on the specific diagnosis:

_____

Does your child take any medication? If so, please list specific name and indication: _____

Does your child have any allergies? Please describe: _____

Has your child had any medical testing and/or undergone any surgeries or hospitalizations? Please include specific dates: _____

Please list all professionals involved in your child's care: _____

_____

Does your child currently receive any other treatments or therapies? Please include when treatment began, therapist's name, frequency and duration: _____

_____

Social History

Please list the primary caretakers for your child (self, nanny, grandparents, etc): _____

Please describe your child's temperament, concentration, attention span, behavior, general awareness, ability to follow directions, ability to play with other children, etc: _____

_____

What play activities does your child enjoy? (music, books, toys, etc): _____

_____

Does your child attend day-care, pre-school, or school? If so, please indicate frequency, duration, & name of school: _____

Does your child have an IEP? _____ What services is your child receiving in school?

_____

Is your child involved in any community activities? (gymnastics, baseball, music class, etc):

_____

Developmental Milestones

Fine Motor Skills:

Hand Dominance: Right Left Both Don't Know

Please write the age these milestones were achieved. If your child has not achieved them, please leave blank.

Retains object in either hand _____

Brings one or both hands to mouth _____

Transfers object from one hand to the other _____

Bangs objects together_____

Takes objects out of a container _____

Puts objects in a container _____

Clapping Hands _____

Puts on shoes/socks _____

Uses pincer grasp _____

Stacks blocks _____

Scribbles on paper _____

Toilets independently _____

Picks up finger food_____

Dress/Undress_____

Sensory Integration:

My child is sensitive to: ☐Sounds ☐Textures ☐Grooming ☐Foods

My child has a difficult time: ☐remaining still ☐ listening to directions ☐transitioning ☐ controlling emotions

Gross Motor Skills:

Please write the age these milestones were achieved. If your child has not achieved them, please leave blank.

Rolls Independently_____
Sits independently _____
Pivots in a circle while on tummy _____
Transitions from sitting to tummy _____
Commando crawl _____
Assumes hands and knees position_____
Crawls on hands and knees_____
Transitions from tummy to sitting _____

Pulls to kneel _____
Pulls to stand _____
Stands Independently _____
Walks with support _____
Walks independently _____
Runs _____
Jumps _____
Stairs: Up _____ Down _____

Speech & Language Milestones

Has your child had an Audiology Evaluation _____

If so, what were the results? _____

Has your child had a history of ear infections? _____

How old was your child when he/she said their first word? _____

How many words does your child currently have? _____

How does your child get his/her needs met? (ie: pointing, leading, words, sentences, etc)

_____

Does your child follow directions? _____

My child: (select any that apply)

☐Uses a bottle ☐Sucks thumb or fingers ☐Uses a pacifier ☐Is breast-feeding

What language(s) are spoken in the home? _____

Oral Motor & Feeding Therapy

**If your child is receiving an oral motor and feeding therapy evaluation, please complete the additional questionnaire found on our website.