From the Heart Therapy Services
PARENT QUESTIONNAIRE
Background Information

Today's Date: yr._____mo.______day_____

Child's Name: ____ Birth date: yr._____mo.______day_____

Address: ____ Chron. Age: yr._____mo.______day_____

____

Phone #: _____________________________________ Emergency #: ______________________________

Person Completing Form: ___________________________________ Relationship: ____________________

Email Address: ____

Family Physician:

Name:____________________________ Address: _____________________________ Phone: _____________

Referred By:

Name:____________________________ Address: _____________________________ Phone: ____________

Medical Diagnosis: ____

School/Day Care: ____ Grade: _______________

Teacher's Name: ____ School Phone: _________________

Please state current concerns and reason for this referral:

____

____

FAMILY COMPOSITION

Mother's Name: ___________________________ Occupation: ________________________

Address: _________________________________ Home Phone: ______________________

_________________________________ Work Phone: _______________________

Marital Status: _____________________________

Father's Name: ___________________________ Occupation: ________________________

Address: _________________________________ Home Phone: _______________________

_________________________________ Work Phone: ________________________

Marital Status: _____________________________

Foster Parent/Guardian's Name: _____________________ Occupation: _________________________

Address: _________________________________ Home Phone: ________________________

_________________________________ Work Phone: _________________________

Siblings/others living at home: Name	Age	Grade

Living Facility - Name of facility: ____

Name:____________________________________ Counselor/Title: ______________________

Address: __________________________________ Phone: ______________________________

__________________________________ Fax _________________Pager: _______________

FAMILY HISTORY

Is there a significant family history of any of the following?

	YES	NO	WHO? RELATION TO CHILD?
Speech Delay or Disorder			
Language Delay or Disorder			
Learning Disabilities			
Physical Challenges			
Genetic abnormalities			
Depression or Bipolar Disorder			
ADD			

PREGNANCY

Check here if your child is adopted ______
Pregnancy was ________ Normal _______ Problems

If problems, what kind? (Please check)

____ Chronic disease
____ Vaginal bleeding
____ Trauma
____ Cyanosis
___ Viral infection
___ Toxemia
___ Accident
___ Physical abnormalities
____ Rh incompatibility
____ Hypertension
____ False labor
____ Other: ________________________________

Were any medications taken during pregnancy? Y or N What were they? Purpose: ________________________

____

History of illegal drug use/abuse? ____

Length of pregnancy: ________ Length of labor: ________ Birth weight: ______________ Apgar: ____

Special considerations: (please check)

____ Cesarean
____ Baby rotated
____ Jaundiced
____ Forceps
____ Premature (# if weeks)
____ Rh Negative
____ Transfusions
____ Cyanosis
____ Breech
____ Cord around neck
____ Twin (1st born, 2nd born)
____ Tube feeding
____ Oxygen
____ Limpness
____ Congenital Defects

Other: ____

Were any meds given during delivery? Y or N What were they? Purpose: _______________________________

____

Length of hospital stay: Infant: __________________________ Mother: ____________________________________

EARLY LIFE

As a newborn my child was: ____

____

Sleep habits: (Did / does he/she have any developed routines for sleeping?)
slept well slept restlessly hardly slept never napped

____

Feeding habits: (Tell about meal times, were / are they pleasant or a difficult time?)
ate well difficulty sucking difficulty swallowing

____

Was your child breast fed? Y or N For how long? _________________
Was your child bottle fed? Y or N For how long? __________________

Food allergies: (list) ____

MEDICAL HISTORY
Please list any ongoing health concerns: ____
____
Are immunizations up to date ? Y or N If not, please indicate reason: _____________________

Current Medications	Reason taken	Amount	Times Daily

Any major illnesses? Y or N If yes, please describe: _________________________________
____

Any hospitalizations? Y or N If yes please complete table below:

Illness/Accident	Date	Length of Stay	Results

Are there any diagnosed mental, physical, or emotional disabilities? Y or N
If yes, please describe: ____

Are there any concerns about physical, mental, or emotional difficulties or abuse? ____________________

History of ear infections? Y or N If yes, how many? ______ Was medication prescribed? Y or N

Is he/she currently on medication for ear infection? If yes, please list: ______________________________

If your child has received any OT/ST/PT evaluations or treatment by any other professionals, please list provider, dates of services, and details: ____
____
____

HEARING
How does child respond to sounds? Does he like or dislike certain sounds or voices, or types of music?
Please state:
____
____

Do you feel your child has difficulty hearing? Y or N

If yes, are there certain situations where he/she responds better to auditory stimuli (i.e., voices/sounds)?____
____

Has child ever had a formal hearing evaluation? Y or N

Where: ____________________________________ When: ____________________________
Physician/Audiologist: _________________________ Results ____________________________

Does your child:	YES	NO	SOMETIMES
talk in a very loud voice?			
turn up the volume on the radio and TV?			
hear you if his/her back is turned?			
hear you talk to him/her from the other room?			
pay attention when other noises are nearby?			

VISION

Are there any special things you've noticed about your child's response to light or the way he/she uses his/her eyes and vision? ____

____

Do you feel your child has any visual difficulties? Yes No
Please describe: ____

____

Has he/she received a formal vision evaluation? Yes No
Where: ____________________ When: ______________________________
Physician: __________________ Results: ______________________________

DEVELOPMENTAL MILESTONES

At what age did your child first:

Roll ____________________ Sit ________________________
Say first word ______________ Speak first sentence ______________
Finger feed ______________ Feed independently ______________
Belly crawl ______________ Use spoon ________________
Crawl on hands/knees __________ Drink from cup ________________
Dress independently ___________ Skip ________________________
Walk ____________________ Run ________________________

What was the child's first language? ______________________________
What language(s) is(are) spoken in the home? __________________________
How does your child currently get around? __________________________
Do you have special concerns or questions about his/her development? ____________________

____

____

My child currently:

Sleeps/naps: _____ inconsistently _____ well _____ restlessly
Eats/drinks: _____ at regular intervals _____ at inconsistent intervals
_____ consistent amounts _____ inconsistent amounts

Comments: ____

____

When did your child gain bowel control: Day ____________ Night __________
When did your child gain bladder control: Day ____________ Night __________
Does he seem awkward, uncoordinated? Y or N If yes, explain: ______________________

____

CURRENT CONDITION

Current health: ____
Current weight: ______________________ Height: ________________
Date of last physical exam: _______________ Physician: ______________
Physical Disabilities: ____