

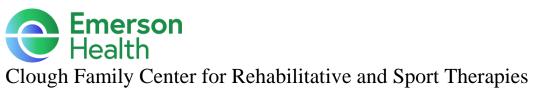
Pediatric Health Questionnaire

Welcome to Emerson Hospital's outpatient services! Please fill this form to the best of your ability, thank you.

<u>SECTION 1</u> (Medical and Social History)
Please list reason(s) you are seeking therapy for your child:
Patient Information
Child's name:
Date of birth:
Caregivers / parents names:
Siblings (ages)/ other people in the home: Who referred your shild for an evaluation (redistriction etc.)?
Who referred your child for an evaluation (pediatrician etc.)?
Are you being hurt or made to feel afraid? □Yes □No
Family History
Please list family history (example: genetic disorder, scoliosis, auto-immune diseases, ADHD/ADD, sensor
processing difficulties, hearing loss, speech/language/learning disabilities):
Languages: Child's primary language:
Are there languages other than English spoken at home/school? Yes No
If yes, which language(s):
Name of school:
Would you like an interpreter? □Yes □No If yes, which language:
Educational and Social History
- Does your child attend daycare or school: □Yes □No If yes, what grade?
- Does your child have an IEP (Individual Education Plan) and receive services at their school?
□Yes □No □ Did not qualify
If yes, what services do they receive through the IEP:
- If no, did your child have an IEP in the past? □Yes □No
- If no, the your child have an IEF in the past: 11 Tes 11 To
Medical History
Name of pediatrician:
Date of last visit with pediatrician:
Reason for Visit:



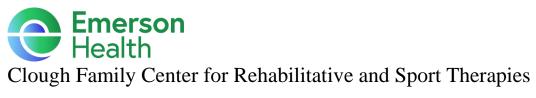
•	diseases, broken bones, or surgeries		
Any history of Seizures? □Yes	□No If yes, list type and medication	s (if any)	
Allergies (if any):			
	sst Weight/Date: Percentile:		
Please check all that apply to yo	our child (past/present):		
☐Congenital heart defect	□Cerebral Palsy	□Cleft lip/palate	
□Respiratory problems	□Down Syndrome	☐Traumatic brain injury	
□Impaired hearing/vision	□Autism	□Concussion	
☐Learning disability	☐ Low or high muscle tone	□Nerve injury or damage	
□ADD/ADHD	□Difficulty swallowing/chewing	□Scoliosis	
□Spasticity	□Mental illness	☐Tongue tie	
□Cleft lip/palate	□Reflux/GERD/Other GI disorders	□Other genetic disorder	
□Upper Respiratory Infections (pneumonia, bronchiolitis)	□Other, please explain:		
•	laptive equipment (wheelchair, utensi		
Activities Please list activities your child e	njoys:		
SECTION 2 (Developmental I	History)		
	r baby during pregnancy? □Yes □N		
	inal, C-section, vacuum assist):ery (need for oxygen, low APGAR so	cores etc.)? □Yes □No	



NICU stay? Yes No If yes please explain: Birth weight:
Any concerns with your child's weight gain or growth? □Yes □No Failure to thrive? □Yes □No
Does/did your child have any of the following: Torticollis? □Yes □No Reflux? □Yes □No
Developmental History
Please list services your child is receiving or has received in the past (example: Early Intervention):
To the best of your ability list the age your child did the following:
Rolling: Crawling: First Word: Sitting: Walking: Combine 2 words:
Sitting:Walking:Combine 2 words:
Do you feel your child met most milestones on time?
Any concerns with regression in any areas (speech/language, gross motor skills)? □Yes □No If yes please explain:
SECTION 3: (Hearing/Communication) How many ear infections has your child had?
Has your child had tubes placed in their ears? ☐Yes ☐No If yes when?
Date of last hearing exam/screen: Who did the hearing test?
Results: □ passed □failed □ other:
Has your child received a formal diagnosis by a medical professional? (e.g Learning Disability Autism
Spectrum Disorder, Down Syndrome, etc.) □Yes □No If yes, when?
What is your child's primary means of communication (e.g. physical manipulation, gestures, sign, speech generating device, words)?
Do you have concerns about your child's communication and/or social skills? □Yes □No If yes, please explain:
What communication goals do you have for your child?



	(Sensory Wotor Skins)
Please	check all that apply:
	Frequently trips on his/her own feet
	Walks on his/her toes
	Frequently bumps into furniture, walls, or other people
	Unaware of being touched or bumped uncles does with extreme force
	Unaware that face or hands are dirty (example: runny nose, food on face)
	Seems unsure of how to move his/her body, clumsy / awkward
	Slumps or slouches when sitting
	Has difficulty learning new motor tasks
	Is in constant motion, difficulty sitting still
	Chews on pends, straws, shirts, etc.
	Frequently touches people and objects
	Is overly sensitive to touch, noise, smells, etc.
	Avoids touching certain textures, please list:
	Avoids mess play (example: finger paints, mud, sand)
	Only eats certain foods or food textures, please list:
	Sensitive to clothing tags or textures
	Does not like hair brushed or teeth brushed
	Does not like to have fingernails trimmed
	Refuses to walk barefoot
Ц	Gets "stuck" on toy or task, difficulty changing to another task
	Fearful of swings, slides, playground structures
	Fearless on playground equipment
	ION 5 (Feeding)
EARL	Y FEEDING HISTORY
Any co	oncerns with dehydration (past/present) Yes No If yes, please explain:
Any co	oncerns with constipation (past/present) Yes No If yes, please explain:
Any co	oncerns with sleep (past/present) \(\subseteq \text{Yes} \subseteq \text{No} \) If yes, please explain:
Was v	our child breast-fed? Yes No If yes, please explain:
	our child latch easily for breastfeeding? Yes No If yes, please explain:
	our child bottle fed? \square Yes \square No If yes, please explain:
	y of dependence on supplemental nutrition? \square Yes \square No If yes, please explain:
	be NG-tube Pediasure Other:
-	our child use a pacifier? Yes No If yes, for how long?
	our child mouth toys as an infant? Yes No
when	did you introduce solid foods?
	were the first foods?
Any p	roblems with solid food introduction? Yes No If yes, please explain:



Any problems with (current or past): Straw drinking? □ Yes □ No If yes, please explain:
Open cup drinking? ☐ Yes ☐ No If yes, please explain:
Spoon Feeding? ☐ Yes ☐ No If yes, please explain:
Chewing? ☐ Yes ☐ No If yes, please explain:
History of (check all that apply): Coughing/choking during or after drinking Wet vocal quality during or after drinking Details: Gagging/vomiting during/after drinking Pain or discomfort during/after drinking
History of (check all that apply):
□MBS □ Feeding team evaluation □FEES □Upper GI □Other:
Dates of evaluations:
Results:
Comments:
CURRENT FEEDING STATUS Briefly, what are your concerns regarding your child's feeding development/skills?
When did you first become concerned about your child's eating?
What made you concerned?
How is your child currently being fed (check all that apply)?
\square G-tube \square NG-tube \square J tube \square Mouth
Bolus Schedule:
Does your child show signs of hunger? ☐ Yes ☐ No
How does your child let you know he/she is hungry?
Length of typical mealtime?
Feeding environment: □high chair □table □walk around □other:
Are feeding times stressful? ☐ Yes ☐ No ☐Sometimes, Comments:
Currently drinks from (check all that apply): □bottle □breast □sippy cup □straw □open cup
Currently eats with (check all that apply): □spoon fed □hands □utensils □pouches
Does your child currently:
□gag during/after feeding □frequently cough during/after feeding
□ food out of nose during or after eating □ choke during feeding
□vomit during/after eating □have a wet vocal quality during/after feeding



Please describe any other behaviors that are of concern (check all that may apply): □overstuffing mouth with food □refuses to eat □frequently drools □spills foods/drinks from mouth □does not chew foods □ mouths objects/fingers □difficulties using cup and/or straw □strong food preferences □pockets food in mouth □avoids specific food textures/groups □avoids face washing □messy eater □strong temperature preferences □picky eater □avoids being messy □strong flavor preferences □throws food □refuses new foods □visible pain or discomfort while swallowing □spits out food □grazes through the day Historically, child consumes adequate amount and variety of: Liquids □ Yes □ No Grains □ Yes □ No Fruits □ Yes □ No Dairy ☐ Yes ☐ No Vegetables ☐ Yes ☐ No Meats □ Yes □ No What does your child eat on a "typical" day? List specific foods and times Morning: Noon: Evening: Overnight: Please report cultural/religious preferences related to feeding: