Patient Questionnaire

Name of Patient _____DOB_____

Name of Parents: _____

Address _____City _____State____Zip Code_____

Pregnancy

1) Was this child a planned pregnancy? Yes No

2) Was the mother under a doctor's care? Yes No

3) Number of previous pregnancies/miscarriages_____

4) Check any of the following complications that occurred during the pregnancy.

☐ Difficulty in Conception	☐ Toxemia	☐ Abnormal weight gain
☐ Measles	☐ Excessive vomiting	☐ German measles
☐ Excessive swelling	☐ Emotional Problems	☐ Vaginal bleeding
☐ Flu	☐ Anemia	☐ High Blood Pressure

☐ Other (Rh incompatibility, etc.) _____

☐ Maternal injury: Describe _____

☐ Hospitalization during pregnancy: Reason _____

☐ X-rays during pregnancy: What month? _____

☐ Medications used during pregnancy: What kind? _____

☐ Alcohol used during pregnancy: Frequency _____

☐ Cigarettes used during pregnancy: Frequency _____

☐ Other drugs used during pregnancy:

Type	Frequency	Prescription
_____	_____	Yes No
_____	_____	Yes No
_____	_____	Yes No

Birth

1) At this child's birth, what was the mother's age? _____ Father's age? _____

2) Mother's age at birth of first child? _____

3) Was this child born in a hospital? Yes No If no, where?_____

Length of pregnancy: _____weeks Birth weight: _____lbs_____oz

Length of Labor:_____hours

Child's condition at birth _____

Mother's condition at birth _____

4) Check any of the following complications that occurred during birth.

☐ Forceps used ☐ Breech birth ☐ Labor induced ☐ Caesarean delivery

☐ Other delivery complications: Describe _____

□ Incubator: How long? _____

□ Jaundiced: Bilirubin lights? Yes No If yes, how long? _____

□ Breathing problems right after birth: Describe _____

Supplemental oxygen? Yes No If yes, how long? _____

5) Was anesthesia used during delivery? Yes No If yes, how long? _____

Length of stay in hospital: Mother _____days Child: _____days

Development

1) At what age did this child do the following? Please indicate year/month of age.

Turn over _____ Walk down stairs_____

Sit alone _____ Show interest in or attraction to sound _____

Crawl _____ Understand first words _____

Stand alone _____ Speak first words _____

Walk alone _____ Speak in sentences _____

Walk up stairs _____

2) Was this child breast-fed? Yes No When weaned? _____

3) Was this child bottle-fed? Yes No When weaned? _____

4) When was child toilet trained? Days: _____ Nights: _____

5) Did bed-wetting occur after toilet training? Yes No If yes, until what age? _____

6) Did bed-soiling occur after toilet training? Yes No If yes, until what age? _____

7) Were there any medical reasons for bed-wetting or soiling? Yes No If yes, please describe _____

8) Has this child experienced any of the following problems? If yes, please describe.

Walking difficulty No Yes _____

Unclear speech No Yes _____

Feeding problem No Yes _____

Underweight problem No Yes _____

Overweight problem No Yes _____

Colic No Yes _____

Sleep Problem No Yes _____

Eating Disorder No Yes _____

Difficulty learning to ride a bike No Yes _____

Difficulty learning to throw or catch No Yes _____

9) During this child's first 4 years, were any special problems noted in the following areas?

If yes, please describe.

Eating	No	Yes _____
Motor skills	No	Yes _____
Sleeping too much	No	Yes _____
Temper Tantrums	No	Yes _____
Sleeping too little	No	Yes _____
Failure to thrive	No	Yes _____
Separating from parents	No	Yes _____
Excessive crying	No	Yes _____

10) Which hand does this child use for writing or drawing? _____

Eating? _____ Other(throwing, etc.)? _____

11) Has this child been forced to change writing hand? No Yes _____

Medical History (childhood illnesses/injuries)

1) Please check the illnesses this child has had and indicate age (year/month).

☐ Measles _____ ☐ Rheumatic Fever _____

☐ German Measles _____ ☐ Diphtheria _____

☐ Mumps _____ ☐ Meningitis _____

☐ Chicken pox _____ ☐ Encephalitis _____

☐ Tuberculosis _____ ☐ Anemia _____

☐ Whooping cough _____ ☐ Fever above 104˚ _____

☐ Scarlet Fever _____ ☐ Head Injury: Describe _____

_____

☐ Coma or loss of consciousness: Describe _____

☐ Sustained high fever: Describe _____

2) Please describe other serious illnesses or operations (note age of child at time of illness or operation) _____

_____

3) Has this child ever been on long-term medication (more than six months)? No Yes

If yes, when? _____ What kind? _____

4) Please indicate whether this child currently has or suffers from any of the following;

☐ Frequent colds ☐ Chronic Cough ☐ Asthma ☐ Hay Fever

☐ Sinus Condition ☐ Shortness of Breath ☐ Heart murmur ☐ Excessive Vomiting

☐ Excessive Diarrhea ☐ Constipation ☐ Stomach Pain ☐ Muscle Pain

☐ Poor posture ☐ Frequent Rashes ☐ Bruises easily ☐ Sores

☐ Severe Acne ☐ Eczema ☐ Seizures ☐ Speech Defects

☐ Accident Prone ☐ Bites Nails ☐ Sucks Thumb ☐ Grinds teeth

☐ Has tics/twitches ☐ Bangs Head ☐ Rocks back & Forth

☐ Urination in Pants/ Bed ☐ Excessive Urination ☐ Bowel Movements in pants/bed

☐ Ear Infections ☐ Hearing problems ☐ Ear Tubes ☐ Vision Problems

☐ Wears glasses or contacts

Family Health

Have any family members had any of the following? If yes, please specify family member's relationship to this child. If child is not living with biological parents, please include health information on biological parents if known.

☐ Cancer _____
☐ Cystic Fibrosis _____
☐ Diabetes _____
☐ Heath Disease _____
☐ High blood pressure _____
☐ Kidney disease _____
☐ Migraine Headaches _____
☐ Multiple sclerosis _____
☐ Physical handicap _____
☐ Stroke _____
☐ Tuberculosis _____
☐ Alzheimer's disease _____
☐ Hemophilia _____
☐ Huntington's chorea _____
☐ Muscular dystrophy _____
☐ Parkinson's disease _____
☐ Sickle-cell anemia _____

☐ Tay-Sachs disease _____
☐ Tourette's syndrome _____
☐ Birth Defect _____
☐ Cerebral palsy _____
☐ Alcohol/Drug abuse _____
☐ Behavior Disorders _____
☐ Emotional Disturbance _____
☐ Mental Illness _____
☐ Mental Retardation _____
☐ Nervousness _____
☐ Seizures or epilepsy _____
☐ Reading problem _____
☐ Other learning disability _____
☐ Speech/language problem _____
☐ Food allergies _____
☐ Severe head injury _____
☐ Other: Describe_____

_____

Describe father's present health: _____

_____

Describe mother's present health: _____

_____

Has anyone in the family ever been in special education? No Yes

If yes, who? _____ What type of class? _____