PATIENT NAME: ______________________

Milestone Pediatric Therapy Services, Inc

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PT QUESTIONNAIRE

Areas of Concern/Goals When did you first have concerns about your child?

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____

What made you concerned?

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____
____

What is your primary concern today?

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____

What specific skills would you like your child to achieve in therapy?

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Pregnancy and Birth History Length of Pregnancy: _______ weeks

Any complications for mother or baby during pregnancy? □ Yes □ No □ Gestational Diabetes □ Pre-eclampsia □ Disorder of Placenta □ High-risk Pregnancy □ Intrauterine Growth Restriction (IUGR) □ Pre-existing Conditions (ex. cardiovascular disease) □ Other, please explain:

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Was the delivery: □ Vaginal □ C-Section □ Induced Any complications with labor or delivery? □ Yes □ No □ Low APGAR scores □ Prolonged delivery □ Meconium aspiration □ Breeched □ Low oxygen □ Abnormal heart rate for baby □ Nuchal Cord (umbilical cord wrapped) □ Use of vacuum/forceps □ Other, please explain

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Any concerns or interventions following birth? □ Yes □ No □ Need for Oxygen □ Seizures □ NICU, length of stay? ____________ □ Jaundice □ NG or G tube placed □ Special Care Nursery □ Congenital Abnormalities □ Genetic Testing □ Small for gestational age (SGA) □ Other, please explain: ____

Medical History

Date of last visit with pediatrician: _________________________________
Pediatrician Name and Practice:

____

Have you seen your pediatrician for: □ Routine visit or physical □ General illness (i.e., flu-like symptoms, cold, congestion, fever, etc.) □ Respiratory Illness □ Ear infections □ Feeding concerns, vomiting, or reflux □ Other (please explain):

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Does your child have any allergies? □ Yes □ No If yes, please list ALL known allergies (i.e., seasonal, latex, peanuts, etc.):

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____

Is your child followed by any specialists? □ Yes □ No Please list/name any specialists and locations:

□ Developmental Pediatrician: ____
□ Cardiologist: ____
□ Neurologist: ____
□ Gastroenterologist (GI): ____
□ Otolaryngologist (ENT): ____
□ Allergist: ____
□ Genetics: ____
□ Feeding Team: ____
□ Other: ____

Has your child received a formal diagnosis by a medical professional? □ Yes □ No □ Autism Spectrum Disorder □ Down Syndrome □ Traumatic Brain Injury □ Concussion □ Developmental Delay □ Cerebral Palsy □ Hearing Loss □ Asthma □ Seizures □ Genetic Disorder □ Learning Disability □ CHARGE

□ Other (please explain):

____

Has your child ever been evaluated for Early Intervention Services? □ Yes □ No

Please check any/all services your family receives or has received in the past:

□ Developmental specialist; how often? ______________

□ Speech-Language Pathologist; how often? ______________

□ Physical Therapist; how often? ______________

□ Occupational Therapist; how often? ______________

□ Parent-child group; how often? ______________

□ Child-only group; how often? ______________

□ Other: ___________________________________; how often? ______________

Motor Development

List approximate age at which your child demonstrated the following skills:

Rolling: ___________ Crawling: __________ Sitting Up: __________ Started to walk: __________ Walked unassisted: __________ Any concerns regarding gross motor skills (i.e., walking up/down stairs, running smoothly, jumping)? Yes _____ No_____ If yes, please explain: ____

Any concerns regarding fine motor skills (i.e., stacking blocks, drawing, cutting, writing)? Yes _____ No_____ If yes, please explain:

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Social and Educational History

Has your child been evaluated for Services through your local public school? □ Yes □ No □ In process of evaluating

Does your child have an Individual Education Plan (IEP)? □ Yes □ No □ Not currently, but in the past

Education and Social History (continued) If yes, what services does/did your child receive: □ Speech/Language Therapy □ Physical Therapy □ Occupational Therapy □ Applied Behavioral Analysis (ABA) □ Vision □ Assistive Technology/AAC □ Social Skills □ Lunch Bunch □ Other: ________________________

Does your child have a Behavior Plan? □ Yes □ No □ Not currently, but in the past Does your child have a 504 Plan? □ Yes □ No □ Not currently, but in the past If yes, what accommodations or modifications are in place?

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Do you have any concerns about your child's attention? □ Yes □ No If yes, please explain:

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Do you have any concerns about your child's behavior(s)? □ Yes □ No If yes, please explain:

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How does your child play? □ Prefers to play alone □ Prefers to play with 1 or 2 others □ Plays mostly with siblings □ Plays with a lot of friends/enjoys groups □ Plays cooperatively □ Requires encouragement to play with others How would you describe your child (reserved, outgoing, energetic, playful, etc.)?

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What are some of your child's favorite activities and/or toys?

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Is there anything regarding your child's educational, attention, behavioral, or social abilities that you would like to share or comment on?

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