Whole Body Wellness and Physical Therapy, llc

78 Eastern Blvd. Glastonbury, CT 06033
Office (860) 430-9122 Fax (860) 430-9142

Carol Gordon, PT, IMT,C
CT License #2520 NPI # 1366581738 EIN 47-1106892

Pediatric: Parent Questionaire

Dear Parent or Guardian: We appreciate your time and care in completing this questionaire. We are aware of its lengthy nature, however, the significance of all of the information cannot be stressed enough. Your diligence with answering will greatly add to our ability to help your child meet their/your goals. Please print clearly in blue or black ink. Please have this form completed in full prior to the child's initial evaluation. Please have this questionaire available for the IMT practitioner privileged with doing the initial intake on your child. Thank you!

Child's Name: _____, _____, _____ - _____
LAST FIRST MI NICKNAME

Date Of Child's Birth: _____
Date Questionaire Completed: _____
Person Completing Questionaire: _____
Relationship To Child: _____

Intervention Team:

Dear Parent, please list all persons participating in your child's care. Please place a checkmark in front of the persons to whom you are requesting an evaluation result to be sent. Thank you!

Referral From: _____ (DC, DO, MD, _____)
Address _____
Phone Number _____
Other: _____ (DC, DO, MD, _____)
Address _____
Phone Number _____
Other: _____ (DC, DO, MD, _____)
Address _____
Phone Number _____
Other: _____ (DC, DO, MD, _____)
Address _____
Phone Number _____
Other: _____ (DC, DO, MD, _____)
Address _____

Signature: _____

Diagnoses:

Dear Parent, please record all diagnoses that your child has been given and provide further details in the space provided. Thank you!

_____
_____
_____
_____
_____
_____
_____

CHILD'S NAME_____DOB_____

Pregnancy/Delivery History:

Dear Parent, please circle historical data and provide added details in space provided. Thank you!

Mother: Cigarettes Alcohol Drugs_____ Infections_____
Complications:_____
Father: Cigarettes Alcohol Drugs_____ Infections_____
Complications:_____
Labor: Home_____Hours Hospital_____Hours Total Hours_____
Induction Drugs_____ Complications_____
Delivery: Natural Cesarean Vaginal Forceps Vacuum
Anesthesia_____ Complications_____
Country: USA Canada Other_____
Apgar Scores:_____ Weight_____ Length_____
Immediate Hospitalization: NICU_____Hours/Days/Months
Nursery_____Hours/Days/Months
Complications:_____
Adopted At Age _____ Months.
Other:_____
_____
_____

CHILD'S NAME _____ DOB _____

Medical History:

Dear Parent, please give an accounting of your child's medical history with ages. Thank you!

Hospitalizations/Surgeries: _____

Infections: _____

Fractures: _____

Seizures: _____

Other Injuries: _____

Other Complications: _____

Dental: _____

Immunizations:

Dear Parent, the "X" signifies the immunization schedule recommended by the American Academy of Pediatrics. Please check the boxes of the vaccinations your child has had. Use the space below for varied information. Thank you!

INDEX: HB = Hepatitis B; HiB = Hemophilus B; VZ = Varicella Zoster; DPT = Diphtheria, Pertussis, and Tetanus; OPV = Polio; MMR = Measles, Mumps, and Rubella (German Measles)

	Months					Years			
Immunization	**0-2**	**2**	**2-4**	**4**	**6**	**6-18**	**12-15**	**12-18**	**3 & over**
HB	X		X			X			
DTP		X		X	X			X	
HiB		X		X	X		X		
OPV		X		X		X			

VZ								X	
MMR							X		

Other:_____

CHILD'S NAME_____ DOB_____

Medication History:

Dear Parent, please list all medications your child has taken and the goal for taking the medication. Thank you!

	MEDICATION	DOSAGE	GOAL
Currently Taking:			
Others In Past Year:			
Prior Years:			
Nutritional Supplements:			

Bracing/Positioners:

Dear Parent, please record all braces, positioners, and assistive devices. Please provide time and frequency of use, as well as the intended purpose of the device. Thank you!

Device	Time/Frequency	Purpose

Sleeping Patterns:

Dear Parent, please circle your child's preferred sleeping position and patterns. Thank you!

Deep Sleeper Light Sleeper Fussy Sleeper Wakes Frequently Cries Frequently
On Back On Abdomen On Left Side On Right Side All Positions
Restless Other:_____ Other:_____
Your child's average number of hours of sleep per night time _____ and per day time _____.

CHILD'S NAME_____DOB_____

Social/Emotional:

Dear Parent, list primary persons in your child's life with relationship and ages. Please place a check mark in front of behaviors that your child has demonstrated. Thank you!

Parents:_____
Siblings:_____
Others:_____
_____

☐	Makes eye contact	☐	Explores surroundings.	☐	Understands "NO"
☐	Smiles often.	☐	Manipulates objects.	☐	Gives hugs.
☐	Vocalizes to socialize.	☐	Wants inclusion in	☐	Loves an audience.
☐	Enjoys social play.		social interactions.	☐	Possessive of toys.
☐	Interested in other	☐	Watches self in mirror.	☐	Shows self awareness
	children.	☐	Anxiety with strangers.	☐	Plays with others.
☐	Shows anticipation.	☐	Seeks approval of	☐	Entertains self.
☐	Shows humor.		parents	☐	Tantrums.

Sensory:

Dear Parent, please circle L (likes) or D (dislikes) or I (indifferent). Thank you!

L	D	I	Hugs	L	D	I	Sand boxes
L	D	I	Stroking	L	D	I	Swings
L	D	I	Bathing	L	D	I	Slides
L	D	I	Hair combing/brushing	L	D	I	Warm water (bathing)
L	D	I	Teeth brushing	L	D	I	Cool water (bathing)
L	D	I	Tags on clothes	L	D	I	Fitted clothes
L	D	I	Finger Painting	L	D	I	Quiet
L	D	I	Tickles	L	D	I	Loud sounds
L	D	I	Surprises	L	D	I	_____

Pain:

Dear Parent, please describe areas of the body that your child complains of pain, range of pain on a 0-10 scale, and any related time or activity that increases the pain. Thank you!

LOCATION RANGE TIME/ACTIVITY INCREASING THE PAIN

_____

_____

_____

_____

_____

CHILD'S NAME_____DOB_____

Motor Development:

Dear Parent, please place a check mark in front of behaviors that your child has demonstrated or currently does demonstrate. If behavior relates to a left or a right side please indicate by circling the L or the R, or Both. Thank you!

INDEX: Prone = Lying on the abdomen, Supine = Lying on the back

- ☐ Prone - Lifts head
- ☐ Prone - Props on elbows
- ☐ Prone - Props on straight arms
- ☐ Hands to mouth L R Both
- ☐ Hands together
- ☐ Hands to feet L R Both
- ☐ Holds objects L R Both
- ☐ Reaches for objects L R Both
- ☐ Lets go of objects L R Both
- ☐ Rolls prone to supine
- ☐ Rolls supine to prone
- ☐ Achieves sitting independently
- ☐ Sits without support
- ☐ Assumes hands & knees
- ☐ Rocks on hands & knees
- ☐ Passes object from one hand to other
- ☐ Picks up small objects L R Both
- ☐ Assumes hands & feet
- ☐ Crawls on belly
- ☐ Crawls on hands & knees
- ☐ Pulls to kneeling
- ☐ Pulls to standing
- ☐ Squats
- ☐ Plays peek-a-boo
- ☐ Stands alone _____ sec/min/hour
- ☐ Walks along furniture
- ☐ Walks holding one hand
- ☐ Stoops to pick up object
- ☐ Walks alone
- ☐ Climbs furniture
- ☐ Climbs stairs
- ☐ Waves bye-bye L R Both
- ☐ Walks up stairs
- ☐ Builds a tower of cubes/objects
  3 4 5 6
- ☐ Stands on one foot
- ☐ Hops
- ☐ Skips
- ☐ Runs
- ☐ Spins
- ☐ Rides bike
- ☐ Kicks ball in standing L R Both
- ☐ Throws objects L R Both
- ☐ ----------
- ☐ ----------
- ☐ ----------

Other:_____

_____

_____

_____

_____

_____

CHILD'S NAME_____ DOB_____

Bowel and Bladder:

Dear Parent, please place a check mark in front of the representative behaviors for your child. Circle time of day and fill other information requested. Thank you!

☐ Wears diapers AM PM

☐ Wears pull-ups AM PM

☐ Wear regular underwear AM PM

Urinates _____ times per day.

Bowel movement _____ times per day/week.

Consistency is typically stonelike - firm - soft and formed - loose - liquid

Uses toilet successfully _____ percent of the day for urinating.

Uses toilet successfully _____ percent of the day for bowel movements

Communication/Hearing:

Dear Parent, please place a check mark in front of behaviors that your child has demonstrated or currently does demonstrate. If behavior relates to a left or a right side please indicate by circling the L or the R, or both. Thank you!

- ☐ Coos
- ☐ Smiles
- ☐ Laughs
- ☐ Clicks.
- ☐ Mmm.
- ☐ Ddd
- ☐ Nnn
- ☐ Bbb .
- ☐ Fff
- ☐ Sss
- ☐ Ggg
- ☐ 1-15 words
- ☐ More than 15 words
- ☐ More than 100 words
- ☐ 2 word phrases
- ☐ 3 word phrases
- ☐ 4 word phrases
- ☐ Unlimited phrase length
- ☐ Memory of past hour
- ☐ Memory of past day
- ☐ Memory of past week.
- ☐ Turns towards voices..
- ☐ Startles to loud noises.
- ☐ Mimics sounds.
- ☐ Enjoys voice play.
- ☐ Enjoys sound toys.
- ☐ Pulls on ear(s). R L
- ☐ No ear infections.
- ☐ 1-3 ear infections.___/yr
- ☐ More than 3 ear infections R L_
- ☐ Tubes in ear(s) R L
- ☐ Wears hearing aids R L
- ☐ Beginning sign language
- ☐ Advanced sign language
- ☐ Communication board
- ☐ Augmentative device
- ☐ Receptive difficulties
- ☐ Expressive difficulties
- ☐ Articulation difficulties
- ☐ Slurring
- ☐ Stuttering
- ☐ Processing delay
- ☐ Uses pacifier
- ☐ _____

CHILD'S NAME_____DOB_____

Dietary:

Dear Parent, please check and circle your child's food intake information. Thank you.

- ☐ Unlimited intake capability
- ☐ Tube fed - nasal GI Tract _____ Location
- ☐ Breast fed
- ☐ Breast milk by bottle and/or cup
- ☐ Formula - type_____
- ☐ Baby foods - types _____
- ☐ Pureed foods - types _____
- ☐ Mixed foods - types _____