

Whole Body Wellness and Physical Therapy, llc

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Pediatric: Parent Questionnaire

Dear Parent or Guardian: We appreciate your time and care in completing this questionnaire. 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 questionnaire 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 Questionnaire Completed: _____

Person Completing Questionnaire: _____

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 _____

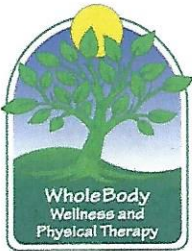
Other: _____ (DC, DO, MD, _____)
 Address _____
 Phone Number _____

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 _____

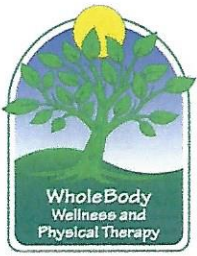
Apgar Scores: _____ Weight _____ Length _____

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: _____

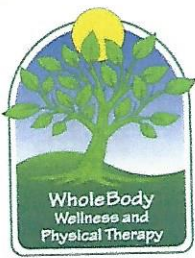
Dental: _____

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

Immunization	Months					Years			
	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:	_____	_____	_____
	_____	_____	_____

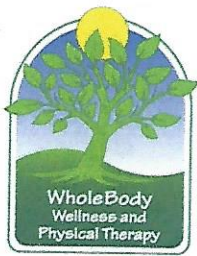
Bracing/Positioners:

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: _____

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

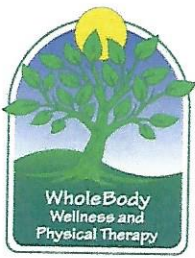
Sensory:

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 _____

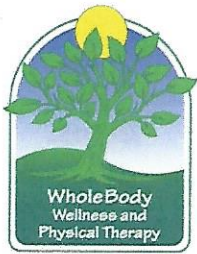
DOB _____

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

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



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

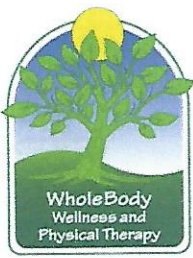
Urinate _____ times per day.

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!

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

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 _____
- _____