Kidz Therapy, LLC
3508 Fort Hill Drive Alexandria, VA 22310 • Kidztherapy@icloud.com • 703-862-6557

HISTORY QUESTIONNAIRE

Thank you very much for taking the time to complete this history. Please answer the following questions as best you can. If there is not adequate space for your comments, please continue to write on the back of this form. Thank you so very much for the privilege to help you help your child!

CHILD AND FAMILY INFORMATION

Child's Name: _____ DOB: _____

Parent Name: _____ Parent Name: _____

Address: _____ Address: _____

_____ _____

Cell #: _____ Cell #: _____

Home #: _____ Home #: _____

Email: _____ Email: _____

Child's Primary Insurance: _____ Name of Person completing this form:

Policy Holder's Name: _____ _____

Address: _____ Relationship to child: _____

_____

Siblings:

1. _____ Age: _____ Grade: _____ Gender: _____
2. _____ Age: _____ Grade: _____ Gender: _____
3. _____ Age: _____ Grade: _____ Gender: _____

Child's primary language: _____ Secondary: _____

Is the primary language spoken in the home? _____

What other languages are spoken in the home? _____

CURRENT CONCERNS/REASON FOR REFERRAL:

_____

_____

_____

When was the concern first noticed and by whom?_____

Has the concern/problem changed since it was first noticed? _____

_____

Is your child aware of the problem? If yes, how does he or she feel about it? _____

_____

Describe your child's current demeanor/behavior: _____

_____

_____

_____

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MEDICAL INFORMATION:

Please circle all that apply and/or fill in the blanks.

Diagnosis: _____

Referring Physician: _____

Physician address: _____

Physician Phone: _____

Physician Fax #: _____

Does your child see other specialist(s)? _____ If yes, please list below.

Physician: _____ Specialty: _____

Physician: _____ Specialty: _____

Physician: _____ Specialty: _____

Other Professional Providers (occupational, physical or speech therapy, counseling, tutoring, etc): Please list name and contact number. Also please list previous therapies or services your child has received and the approximate dates s/he received them.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Do other family members have any speech, motor, cognitive, or other diagnoses/delays? If yes, please describe:

_____

_____

Pregnancy and Birth:

Please circle Yes or No to the following questions and remark in the space provided.

1. Were there any infections/illnesses during pregnancy? Yes or No

2. Were there any drugs or medications taken during pregnancy? Yes or No

3. Was there any unusual stress during pregnancy? Yes or No

4. Was the pregnancy full-term? Yes or No
   Premature delivery? Yes or No If yes, weeks gestation? _____

5. Was the labor normal? Yes or No

6. Was the delivery normal? Yes or No (Explain ex: Cesarean section, breech, sideways, cord around neck, forceps used.) _____
_____

7. Was medication given during delivery? Yes or No _____

8. Were there any other complications during the pregnancy? Yes or No _____

9. What was the child's weight at birth? _____ Apgar Scores: 1 min_____ 5 min_____

10. Were there any complications (i.e. seizures, jaundice, congenital defects other)? Yes or No _____
_____

11. Was there a need for: oxygen, transfusions, tube feedings, other: _____

12. Did your infant cry right away? Yes or No _____

13. What was the length of the infant's hospital stay? _____

14. Was your child breastfed or bottle-fed? How long? _____

15. Did the infant have any feeding problems? _____

16. Please state any other difficulties or special cares:

History of Major Illness:

If applicable, provide approximate age at which the child had the following illnesses/conditions:

High Fever (above 103.5 F): _____
Pneumonia: _____
Meningitis: _____
Seizures: _____
Chicken Pox: _____
Headaches: _____
Mastoiditis: _____
Tonsillitis: _____
Other: _____

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History of hospitalizations: _____
_____
_____

History of ear infections: Yes or No; If yes, how many: _____
Tonsillectomy and/or adenoidectomy: Yes or No _____
When was your child's most recent hearing exam? _____ Results: _____
Is child currently on medication for ear infection? Yes or No _____
Are there any diagnosed mental, physical or emotional disabilities? Yes or No _____
_____
Are there any concerns about physical, sexual, mental or emotional abuse? Yes or No
Were any of these conditions chronic? Yes or No If so, which ones and how often did they occur? _____
_____

Current Health:

Current weight: _____ Current height: _____
Date of last physical exam: _____ Results: _____
Current Medications/Dosage/Frequency: _____
_____
_____

Known Allergies: Yes or No If yes, please list and give severity of reactions (ie anaphylaxis; mild or severe rashes, etc.): _____
_____
_____

Food Allergies/Restrictions: _____
_____
_____

Are immunizations up to date: Yes or No

Sleep Schedule:

My child currently sleeps/naps (circle one): inconsistently well restless other
Bedtime: _____ Duration: _____ Wakes at: _____
Naps/day: _____ Nap time(s) of day: _____ Duration: _____

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DEVELOPMENTAL HISTORY

1. Do you feel that your child met his/her developmental milestones on time when compared to peers or siblings?_____
_____

2. Does your child appear to participate in age appropriate movement activities (i.e. riding a bike, skipping, etc.)
_____

3. Do you have concerns or questions about his/her development? If yes, please explain:_____
_____

4. Describe your child's demeanor and behavior as an infant: _____
_____

5. Describe the child's response to sound (e.g., responds to all sounds, responds to loud sounds only, inconsistently responds to sounds, distracted by sounds, etc.): _____
_____
_____

6. What do you see as your child's strengths? _____
_____
_____
_____
_____

Developmental Milestones:

Please list the age that your child did the following and answer questions below (in months).

Skills	Age in Months	Not achieved yet
Roll		
Sit		
Belly crawl		
Crawl on hands/knees		
Walk		
Run		
Skip		
Said first word		
Finger fed		
Used spoon		
Drank from cup		

Skills	Age in Months	Not achieved yet
Dressed independently		
Used the toilet independently		
Bladder control		
Bowel control		

Used single words (e.g., no, mom, doggie, etc.): Yes or No Age in Months: _____

Combined words (e.g., me go, daddy shoe, etc.): Yes or No Age in Months: _____

Asks simple questions (e.g., Where's doggie? etc.): Yes or No Age in Months: _____

Engaged in a conversation: Yes or No Age in Months: _____

How well do *you* understand your child's speech? _____
In context: _____% of the time; out of context _____% of the time

How well do *others* understand your child's speech? _____
In context: _____% of the time; out of context _____% of the time

Self Help Skills:

1. Does your child resist having his/her:
Teeth brushed? Yes or No Hair brushed? Yes or No Face washed? Yes or No

_____
_____

2. Are there or have there ever been any feeding problems (e.g., problems with sucking, swallowing, drooling, chewing, gagging, aspirating, etc.)? If yes, describe: _____

_____
_____
_____

3. Is your child a picky eater? Yes or No If so, what texture/temperature preferences have you observed?

_____
_____
_____
_____

4. My child currently eats/drinks at: (circle one for each choice)
- Regular or irregular intervals - Consistent or inconsistent amounts

_____
_____

5. Check applicable box for level of assistance needed for each activity of daily living.

ACTIVITY	Independent	25% Help	50% Help	75% Help	100% Help
Toileting					
Sits on potty					
Wipes self					
Washes hands					
Dries hands					
Bathing					
Gets in/out of tub/shower					
Washes hair					
Washes body					
Washes face					
Dries self					
Brushes teeth					
Combs/Brushes hair					
Dressing					
T-shirt					
Pants/shorts					
Socks					
Shoes					
Lace shoes					
Velcro shoes					
Dresses in a timely manner					
Selects own clothes appropriate for season					
Feeding					
Uses cup					
Uses spoon					
Uses fork and knife					

Oral Motor	Yes	No	Some
Chews with closed mouth			
Swallows food with no gagging			
Overstuffs mouth			
Eats a variety of foods and textures			

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SOCIAL/EDUCATION HISTORY:

School/Day Care: _____ Grade: _____

Teacher's Name: _____ Phone: _____

How is your child doing academically (or pre-academically)? _____

_____

_____

Does your child receive special services in school? If yes, describe: _____

_____

_____

Activities your child enjoys: _____

_____

_____

Does your child prefer to do these activities alone or with other children/siblings? _____

_____

Are there any cultural or religious beliefs that you would like us to be aware of and/or take into consideration when we are working with your child? _____

_____

_____

_____

_____

_____

PLEASE USE SPACE BELOW FOR ANY ADDITIONAL COMMENTS:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____