



Therapy Scan

Witwer Children's Therapy Medical History Questionnaire

Date: _____ Form Completed By: _____ Relation to Child: _____

Child's Name _____
(First) (Middle) (Last)

Date of Birth: _____ Age: _____ Sex: M / F

Formal Diagnosis: _____

When diagnosed and by whom? _____

Is your child presently receiving any Speech therapy _____ Occupational therapy _____ Physical therapy _____
from any other organization/clinic? Yes/no

If yes, where? _____

Is your child having any difficulties in school? Y / N If yes, please explain. _____

Please list other health care providers or agencies that would have information that would be helpful to
have for your child's care at Witwer. Please list name and date of last visit. _____

Has your child had psychological, neurological, or educational testing in the past? Y / N

If yes, when evaluated and by whom? _____

Has your child received therapy in the past for developmental problems? Y / N

If yes, When? _____

From whom/where? _____

How long? _____

Current Medications: _____

Allergies: _____

CONCERNS/GOALS:

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

2. What are your main concerns regarding your child?

3. Are there other family members with this type of problem? If yes, explain _____



PATIENT LABEL

4. What do you hope to gain from therapy? What are your goals for your child?

SOCIAL HISTORY:

Guardian 1: _____ Age: _____ Education: _____

Guardian 2: _____ Age: _____ Education: _____

Parents are currently (circle one): married / separated / divorced

Child lives with: _____

Are there other children in the family? Y / N If yes, please list names/ages: _____

Parents Work Outside Home? Y / N If yes, where and what hours?

Guardian 1: _____

Guardian 2: _____

Child is: _____ at home with care provider _____ (name)

_____ at daycare. Where? _____ Hours/Days? _____

_____ at school. Where? _____ What grade? _____

Teacher name: _____

Special Services at school (IEP, aide, etc) _____

Is Child Adopted? Y / N If yes, when? _____

Is Child in Foster Care? Y / N If yes, how long has child lived with you? _____

Are the child's biological parents involved in their care? Y / N _____

PAST MEDICAL HISTORY:

Mother's Health During Pregnancy:

1. Infections/Illnesses/Injuries? Y / N If yes, what? _____

2. Medications During Pregnancy? Y / N If yes, what? _____

3. Drug/Alcohol/Tobacco Exposure? Y / N If yes, what? _____

4. Unusual Stress? Y / N If yes, what? _____

Labor and Delivery:

1. Natural onset of labor / medication induced

2. Vaginal / C-Section: why? _____

3. Was delivery assisted by forceps or vacuum extraction? Y / N _____

4. Complications during delivery? Y / N If yes, what? _____

Child's Birth History:

1. Premature? Y / N If yes, how many weeks? _____

2. In NICU? Y / N If yes, for what and how long? _____

3. Breathing problems? Y / N (needed oxygen, ventilator, etc) _____

4. Heart Problems? Y / N If yes, what? _____
5. Birth Weight: _____
6. Birth Injuries/Abnormalities: _____
7. Infections? Y / N If yes, what? _____
8. Seizures? Y / N

Child Medical History:

1. Any Significant Accidents/Illnesses/Hospitalizations? Y / N If yes, explain _____
2. Has your child had any surgeries? Y / N If yes, please list surgery and date: _____
3. Does your child have a shunt? Y / N If yes, is the shunt adjusted magnetically? Y / N
4. History of Ear Infections? Y / N If yes, generally when and how many? _____
5. History of Skin Conditions? Y / N If yes, explain _____

6. Latex Allergy Screening Questions:

- o Health History
 - o Has your child ever been diagnosed with a Latex Allergy or Sensitivity? Y / N
 - o Does your child have a diagnosis of Spina Bifida? Y / N
 - o Is your child on an intermittent catheterization program? Y / N
 - o Has your child had multiple surgeries? Y / N
- o Has your child ever had hives, red itchy swollen hands (within 30 minutes) or “water blisters” (within a day) following exposure to:
 - o Balloons Y / N
 - o Bananas Y / N
 - o Avocados Y / N
 - o Kiwi Y / N
 - o Elastic in underwear Y / N
- o Has your child experienced swelling or difficulty breathing after blowing up a balloon? Y / N
- o Do rubber handles, rubber bands or elastic bands on clothing cause any discomfort? Y / N
- o Has your child ever had itchy, red eyes, fits of sneezing, runny or stuffy nose, itching of the nose or palate, shortness of breath, wheezing, chest tightness or difficulty breathing when exposed to any of the above listed items? Y / N

7. Difficulties with the following:

	PAST	PRESENT	FREQUENCY
a. Diarrhea	_____	_____	_____
b. Constipation	_____	_____	_____
c. Stomach Ache	_____	_____	_____
d. Headache	_____	_____	_____
e. Vomiting	_____	_____	_____



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8. Vision Checked? Y / N If yes, when and where? What were the results? _____
 _____ Glasses? Y / N
9. Hearing Checked? Y / N If yes, when and where? What were the results? _____

10. Exposure to lead? Y / N If yes, when and where? _____

FEEDING HISTORY:

1. Breast fed? Y / N If yes, how long? _____
2. Bottle fed? Y / N If yes, how long? _____
3. Feeding difficulties as a baby? Y / N If yes, explain _____

4. Difficulty transitioning off the bottle? Y / N
5. Frequent spit-ups or vomiting as an infant? Y / N
6. Diagnosis of gastroesophageal reflux? Y / N
7. Switched formulas? Y / N If yes, why? _____
8. Difficulty transitioning to regular foods? Y / N
9. History of/present difficulty gaining weight? Y / N If yes, explain _____

DEVELOPMENTAL HISTORY:

If your child is an infant:

What type of infant equipment do you use with your baby?

___ bouncer ___ swing ___ bumbo seat ___ baby walker ___ exer-saucer ___ Johnny Jumper

Does your baby sleep in a car seat or bouncer seat? Y / N If yes, how often?

___ daily ___ 3-5 times a week

Does your baby tolerate "tummy time"? Y / N

Please list the age at which your child met these milestones:

Rolled over: _____

Sat Independently: _____

Crawled: _____

Walked: _____

Spoke First Word: _____

Spoke First Sentence: _____

Toilet Trained: Day: _____ Night: _____



PATIENT LABEL

CURRENT FUNCTIONAL STATUS:

Current Feeding/Nutrition:

1. Current Weight/Height: _____

Any concerns with growth? Y / N

2. What are your child's preferred foods?

3. Is there gagging/coughing/choking with foods? Y / N

If yes, please explain types of food/frequency _____

4. Are you concerned regarding food variety or nutrition? Y / N

If yes, please explain _____

Daily Routines:

1. Please describe the following:

AM ROUTINE: _____

DAY ROUTINE: _____

BEDTIME ROUTINE: _____

SLEEP (the ability to fall asleep, stay asleep, wake on own, etc.): _____

2. Please describe the following:

Events/situations that make your child irritable: _____

Strategies used to calm your child: _____

Who/What your child likes to play with: _____

How your child TRANSITION from activities/events throughout the day: _____

Is there any other information regarding your child that you believe would be helpful?

