Therapy Scan

UnityPoint Health
St. Luke's Hospital

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) _____
_____

PATIENT LABEL

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:
   - Health History
     - Has your child ever been diagnosed with a Latex Allergy or Sensitivity? Y / N
     - Does your child have a diagnosis of Spina Bifida? Y / N
     - Is your child on an intermittent catheterization program? Y / N
     - Has your child had multiple surgeries? Y / N
   - Has your child ever had hives, red itchy swollen hands (within 30 minutes) or "water blisters" (within a day) following exposure to:
     - Balloons Y / N
     - Bananas Y / N
     - Avocados Y / N
     - Kiwi Y / N
     - Elastic in underwear Y / N
   - Has your child experienced swelling or difficulty breathing after blowing up a balloon? Y / N
   - Do rubber handles, rubber bands or elastic bands on clothing cause any discomfort? Y / N
   - 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	_____	_____	_____

PATIENT LABEL

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?

_____
_____

PATIENT LABEL