



**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 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 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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

**SOCIAL HISTORY:**

Father's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Education: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ 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?

Father: \_\_\_\_\_

Mother: \_\_\_\_\_

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	_____	_____	_____

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 \_\_\_\_\_

**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?**

\_\_\_\_\_