BRAZOSPORT REHABILITATION & WELLNESS, L.L.C.

321 Garland Drive, Lake Jackson, TX 77566 Phone: (979) 297-3365 Fax: (979) 297-3541

Pediatric Intake Questionnaire

|  |  |
| --- | --- |
| Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  How did you hear about us?? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diagnosis: (list all):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  MD#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Reason for Evaluation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**THERAPY PRECAUTIONS** - Please be specific

|  |  |  |  |
| --- | --- | --- | --- |
| Does your child have any food allergies or any other allergies you are aware of? Please list. | YES | NO |  |
| Are there any precautions not listed that we should know about. Please describe | YES | NO |  |

**FAMILY HISTORY**

|  |
| --- |
| Father’s Name: Age: Occupation: |
| Mother’s Name: Age: Occupation |
| Is child adopted? If so at what age, and from where/what country? |
| Are parents (circle one): Married Living together Separated Divorced Remarried |
| Who lives in the house with this child, other than parents? (If children are listed, give name and ages) |
| Have there been any instances of the following in your immediate or extended family members:   ADD/ADHD  Learning Disabilities  Communication Disorders  Autism/PDD  Hearing Loss  Stuttering |

**PREGNANCY AND BIRTH HISTORY**

|  |  |  |  |
| --- | --- | --- | --- |
|  | YES | NO | COMMENTS |
| 1. Were there any illnesses, injuries, bleeding, or any complications during this pregnancy? Describe |  |  |  |
| 2. Was this pregnancy full-term? If no, please give gestational age and weight at time of delivery. |  |  |  |
| 3. Were any drugs or medications taken during this pregnancy? If so, please specify. |  |  |  |
| 4. Was labor and delivery normal? |  |  |  |
| 5. Was the delivery vaginal, breech, or caesarian? Were forceps/suction used? |  |  |  |
| 6. Was there a need for oxygen, ventilator, transfusions, tube feedings? |  |  |  |
| 7. Was the length of the infant’s stay in the hospital unusually long? If so, why? |  |  |  |
| 8. Were there any feeding difficulties after birth including problems sucking or nutrient intake? Please specify. |  |  |  |
| 9. Did your child bottle feed or breast feed? |  |  |  |
| 12. Were there any issues with sleep patterns, If so, please explain. |  |  |  |

**MEDICAL HISTORY:** Has your child had any of the following illnesses? (please circle)

adenoidectomy encephalitis seizures

allergies respiratory illness/asthma vision problems

ear infections head injury sleeping difficulties

How many? \_\_\_\_\_\_\_ high fevers thumb/finger sucking

ear tubes swallowing/feeding problems tonsillectomy

Which ear? L R tonsillitis vomiting/reflux

Currently in? Yes No When inserted? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MD? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last hearing screening? Date: \_\_\_\_\_\_\_\_\_\_\_ Pass Fail Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child use any adaptive equipment? Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medications:

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Dosage | Frequency | Reason for taking |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Please describe any pertinent medical conditions not mentioned above. (ie, accidents, injuries, procedures…)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GROWTH AND DEVELOPMENT**

|  |  |  |  |
| --- | --- | --- | --- |
| Did your child do the following: | YES | NO | AGE (please specify as near as possible) |
| 1. Roll over from stomach to back? |  |  |  |
| 2. Roll over from back to stomach? |  |  |  |
| 3. Sit independently? |  |  |  |
| 4. Crawl? |  |  |  |
| 5. Cruise around furniture? |  |  |  |
| 6. Walk? |  |  |  |
| 7. Speak his/her first word? What was it? |  |  |  |
| 8. Speak combined words? |  |  |  |
| 9. Speak his/her first sentence? |  |  |  |
| 10. Feed self independently? What type of utensils? |  |  |  |
| 11. Dress self independently? |  |  |  |
| 12. Toilet trained? |  |  |  |
| 13. Toilet trained through night? |  |  |  |

**COMMUNICATION HISTORY**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | COMMENTS | | | |
| 1. How does your child communicate at home, at school…? |  | | | |
| 2. Estimate how many words are in your child’s vocabulary? | Expressive (speaking vocab) \_\_\_under 25 \_\_\_25-75 \_\_\_over 75  Receptive (words they understand) \_\_\_ under 25 \_\_\_25-75 \_\_\_ over 75 | | | |
| 3. Does your child | | YES | NO | COMMENTS |
| 1. Point or gesture to communicate needs? | |  |  |  |
| b. Understand and follow simple directions? | |  |  |  |
| 4. Does you child have a hearing loss? | |  |  |  |
| 5. Does your child use a pacifier/suck thumb? | |  |  |  |
| 6. Is a language other than English spoken at home? If so, which one? | |  |  |  |
| 7. Please describe any communication difficulties. | |  |  |  |
| 8. When was the problem first noticed? | |  |  |  |

**SOCIAL/EMOTIONAL DEVELOPMENT**

|  |  |  |  |
| --- | --- | --- | --- |
|  | YES | NO | COMMENTS |
| 1. Is your child easily managed at home? |  |  |  |
| 2. Who manages him/her best? |  |  |  |
| 3. Does your child empathize with other’s feelings? (happy, sad, angry…)? |  |  |  |
| 4. Does your child understand punishment and does he/she show remorse? |  |  |  |
| 5. Does your child understand praise and reward? |  |  |  |
| 6. Does your child recognize danger (climbing on things…)? |  |  |  |
| 7. Does your child show concern when separated from parents? |  |  |  |
| 8. Is your child affectionate toward familiar adults? |  |  |  |
| 9. Does your child have friends? |  |  |  |

**EDUCATIONAL BACKGROUND**

|  |  |  |  |
| --- | --- | --- | --- |
|  | YES | NO | COMMENTS |
| 1. Does your child attend school? Where? |  |  |  |
| 2. What grade is he/she in now? |  |  |  |
| 3. Does your child receive special education services in school? (PPCD, pull out, self-contained) |  |  |  |
| 4. Does you child receive therapies in school? (PT, OT, Speech, frequency, length of sessions, individual/group…)? |  |  |  |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ( Sign) I acknowledge that I have received, reviewed, understand and agree to the Notice of Privacy Practices of BRAZOSPORT REHABILITATION & WELLNESS, L.L.C (HIPAA) and BRAZOSPORT REHABILITATION & WELLNESS, L.L.C policies and procedures regarding the use and disclosure of any of my protect health information created, received and maintained by BRW. (version 12/2019)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Sign) I hereby give consent for myself or my child (if a minor) to receive medical treatment at BRW.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Sign) I hereby authorize my insurance carrier, plan, organization, hospital, employer, surgeon, physician, or anesthetist to release any information concerning my care that is requested by BRAZOSPORT REHABILITATION & WELLNESS, L.L.C.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Sign) I have read the BRW financial agreement and understand my financial responsibility for treatment rendered at BRAZOSPORT REHABILITATION & WELLNESS, L.L.C. (version 12/2019)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Sign) I have received/reviewed the attendance policies for Brazosport Rehabilitation and Wellness, LLC. (version 12/2019)