PEDIATRIC HEALTH QUESTIONNAIRE

The purpose of this questionnaire is to provide background information about your child and to express any concerns about your child. Some questions may not apply to every child, but we ask that you fill this out to the best of your ability and avoid leaving sections blank. Feel free to write in the margins or provide any additional information within the comment section as you complete this questionnaire. Thank you!

DEMOGRAPHIC & FAMILY INFORMATION

Child's Name: _____ **Nicknames**: _____

Date of Birth: _____ **Age:** Sex: **M** ☐ **F** ☐ **Other** ☐

Caregivers' Names: _____

Siblings: _____ **Age:** _____

Siblings: _____ **Age:** _____

Siblings: _____ **Age:** _____

Siblings: _____ **Age:** _____

Pediatrician: _____

What are your goals and/or expectations for this evaluation through Emerson Hospital? _____

_____

FAMILY HISTORY

Child's primary language? _____

Are there any other languages spoken at home/school besides English? ☐ YES

What language(s):

Is there a parent, sibling, or family history of?

☐Speech and/or Language Delays or Disorders
☐Learning delay or disability
☐ADHD/ADD
☐Sensory Processing Difficulties
☐Feeding difficulty/Eating disorder
☐Autism Spectrum Disorder
☐Genetic Disorder:
☐Other:

If any box is checked, please explain: _____

PREGNANCY AND BIRTH HISTORY (If your child is under 3 years old)

Length of Pregnancy (Weeks): _____

Any complications for mother or baby during pregnancy?

☐Gestational Diabetes ☐Pre-eclampsia ☐Disorder of Placenta ☐High-risk Pregnancy

☐Pre-existing Conditions (ex. cardiovascular disease, diabetes)

Other**:** _____

Was the delivery:
☐Vaginal ☐C-Section ☐ Induced Forceps ☐Vacuum Assisted

Any complications with labor or delivery? ☐ YES
☐Low APGAR scores ☐Prolonged delivery ☐Nuchal Cord (umbilical cord wrapped)
☐Low oxygen☐Meconium aspiration☐Breeched
☐Other, please explain: _____

Birth weight: _____ Birth length: _____
Any concerns or interventions following birth:
☐Special Care Nursery ☐NICU ☐Need for oxygen ☐Jaundice ☐NG or G tube placed
☐Seizures ☐Congenital Abnormalities ☐Genetic Testing ☐Failed Newborn Hearing Screen
☐Other, please list" _____
Please list how long your child required any interventions checked above: _____
_____

MEDICAL HISTORY

In the past 6 months,
Date of last visit with Pediatrician: _____
Have you seen your pediatrician for: _____
☐Routine visit or physical ☐General illness (i.e., flu-like symptoms, cold, congestion, fever, etc.)
☐Respiratory Illness (pneumonia, bronchitis) ☐Ear infections . No. of ear infections
☐Other (please explain): _____

Does your child have any allergies (including food)? ☐ Yes
If yes, please list ALL known allergies (i.e., seasonal, latex, peanuts, etc.): _____

Does your child have any food intolerances? ☐ Yes
If yes, please list foods: _____

Any family history of food allergies or intolerances? ☐ Yes
If yes, please explain: _____
Any history of congenital malformations, deformations, and chromosomal abnormalities?
☐ Yes ☐ No. Details including treatment: _____

Any history of vomiting, spit up, slow gastric emptying, or gastroesophageal reflux?
☐ Yes ☐ No. Current medications for reflux:
If yes, please explain: _____

Any history of surgeries? ☐ Yes ☐ No If yes, when and type of surgery.

Any concerns with weight gain or growth? ☐ Yes
Most recent weight: _____ Date of weight: _____
Growth chart percentile: _____
Are there issues with constipation? ☐ Yes
If yes, please explain: _____

Current Medications for constipation: _____

History of dehydration? ☐ Yes
If yes, please explain: _____

Are there concerns with sleep? ☐ Yes
If yes, please explain: _____

Has your child had any hospitalizations, serious illnesses, or accidents? ☐Yes
If yes, please explain: _____

Please list any specialists (with location) following your child
☐Developmental Pediatrician: _____
☐Cardiologist: _____
☐Neurologist: _____
☐Gastroenterologist (GI): _____
☐Otolaryngologist (ENT): _____
☐Allergist: _____
☐Genetics: _____
☐Feeding Team: _____
☐Other: _____

Please list current medications: _____

High Blood Pressure: YES☐	**Diabetes: YES☐**	**Stroke: YES☐**
Congenital Heart Defect: YES☐	**Frequent Urination: YES☐**	**Concussion: YES☐**
Respiratory Problems: YES☐	**Kidney Disease: YES☐**	**Traumatic Brain Injury: YES☐**
Asthma: YES☐	**Bowel/Bladder Incontinence: YES☐**	**Thyroid Disorder: YES☐**
Shortness of Breath: YES☐	**Crohn's Disease: YES☐**	**Depression: YES☐**
Lung Disease: YES☐	**Ulcerative Colitis: YES☐**	**Mental Illness: YES☐**
Intubation: YES☐	**Excessive Thirst: YES☐**	**Anxiety: YES☐**
Persistent Cough: YES☐	**Impaired Vision: YES☐**	**Broken Bones: YES☐**
Tuberculosis: YES☐	**Glasses/Contacts: YES☐**	**Scoliosis: YES☐**
Croup: YES☐	**Strabismus: YES☐**	**Torticollis: YES☐**
Upper Respiratory Infection: YES☐	**History of Cancer: YES☐**	**Low muscle tone: YES☐**
Pneumonia: YES☐	**Radiation: YES☐**	**Spasticity: YES☐**
Seizure: YES☐	**Chemotherapy: YES☐**	**Muscular Dystrophy: YES☐**
Tremors: YES☐	**Tumor: YES☐**	**Cleft Lip: YES☐**
Nerve Damage: YES☐	**AIDS: YES☐**	**Impaired Hearing: YES☐**
Paralysis: YES☐	**Arthritis: YES☐**	**Hearing Aids: YES☐**
Lead exposure: YES☐	**Cleft Palate: YES☐**	**Cochlear Implant: YES☐**
PDD-NOS: YES☐	**Joint Pain/Stiffness: YES☐**	**Frequent Ear infections: YES☐**
Asperger's Syndrome YES☐	**ADD/ADHD: YES☐**	**PE tubes(Ear tubes): YES☐**
Cognitive Delay/Learning Disability: YES☐	**Autism: YES☐**	**Dizziness: YES☐**
Lupus: YES☐	**Tongue Tie: YES☐**	**Difficulty Swallowing/Chewing: YES☐**
Heartburn/Reflux: YES☐	**Chronic Pain: YES☐**	**Feeding Tube (G,J,NG): YES☐**
Failure To Thrive: YES☐	**Bleeding Disorder: YES☐**	**Metabolic Disorder: YES☐**
General Fatigue: YES☐	**MRSA: YES☐**	**C-Diff: YES☐**
Headaches: YES☐	**Other: _____**	**_____**

DEVELOPMENT HISTORY

Has your child ever been evaluated for Early Intervention services? ☐ Yes

Please list any/all services your family receives or has received in the past: _____

If your child is under 3 years, to the best of your ability, please list the age your child demonstrated the following developmental skills.

Gross Motor:

Rolled over: _____ Sat up: _____ Crawled: _____ Walked: _____First Word: _____

Are there any areas of concern you have regarding developmental milestones? ☐ Yes

☐Gross motor (walking, jumping, etc.)

☐Fine motor (hand grasp, utensil use)

☐Sensory processing (sensitive or ignores various sounds, textures, lights, etc.)

☐Social engagement (eye contact, attention, playing with others)

☐Speech/Communication (gesture use, use of words, clear speech)

☐Concerns regarding regression in development? _____

EDUCATIONAL AND SOCIAL HISTORY

Does your child attend school or daycare? ☐ Yes ☐ No

School/Daycare: _____ Location: _____

Grade /Level: _____

Are there Concerns around eating at school? ☐ Yes ☐ No

If yes, please explain: _____

Has your child been evaluated for Services through your local public school? ☐ Yes ☐ No ☐ In process

Does your child have an Individual Education Plan (IEP)? ☐ Yes ☐ No ☐ Not currently, but in the past

Please explain: _____

SENSORY MOTOR SKILLS

Please check any statements that describe your child:

☐Frequently trips on his/her own feet

☐Walks on his/her toes

☐Frequently bumps into furniture, walls, or other people

☐Unaware of being touched or bumped unless done with extreme force

☐Unaware that face or hands are dirty (i.e., nose running, food on face)

☐Seems unsure of how to move his/her body; is clumsy and awkward

☐Slumps or slouches when sitting; places head on hand when sitting

☐Has difficulty learning new motor tasks

☐Is in constant motion

☐Has difficulty sitting still

☐Chews on pens, straws, shirts, etc.

☐Frequently touches people and objects

☐Frequently gets in everyone else's space

☐Is overly sensitive to touch, noise, smells, etc.

☐Avoids touching certain textures (please list: _____

☐Avoids messy play (i.e., finger paints, playdough, mud, sand)

☐Only eats certain foods or food textures (please list: _____

☐Is sensitive to clothing tags or textures

☐Complains about having hair brushed

☐Resists having teeth brushed

☐Does not like to have fingernails trimmed

☐Refuses to walk barefoot

☐Gets “stuck” on toy or task and has difficulty changing to another task
☐Is fearful on swings
☐Is fearful of slide or other playground structures
☐Is fearless on playground equipment

Comments about your child’s sensory or motor skills that might help us better understand your child:
_____

If you are here for a feeding evaluation for your child, please continue below, if not, stop her

EARLY FEEDING HISTORY

Was your child breast fed? ☐ Yes ☐ No Comments: _____

Did your child latch easily for breastfeeding? ☐ Yes ☐ No Comments: _____

Was your child bottle fed? ☐ Yes ☐ No Comments: _____

History of dependence on supplemental nutrition? ☐ Yes ☐ No When: _____

☐G-tube ☐ NG-tube ☐Pediasure ☐Other : _____

Did your child use a pacifier? ☐ Yes ☐ No For how long? _____

Did your child mouth toys as an infant? ☐ Yes ☐

When did you introduce solid foods? _____

What were the first foods? _____

Any problems with solid food introduction? ☐ Yes ☐ No

If yes, please explain: _____

Any problems with (current or past):

Straw drinking? ☐ Yes ☐ No If yes, please explain: _____

Open cup drinking? ☐ Yes ☐ If yes, please explain: _____

Spoon Feeding? ☐ Yes ☐ No If yes, please explain: _____

Chewing? ☐ Yes ☐ No If yes, please explain: _____

History of (check all that apply):

☐Coughing/choking during or after drinking

☐Gagging/vomiting during/after drinking

☐Wet vocal quality during or after drinking

☐Pain or discomfort during/after drinking

Details: _____

History of (check all that apply):

☐MBS ☐ Feeding team evaluation ☐FEES ☐Upper GI ☐Other : _____

Dates of evaluations: _____

Results: _____

Comments: _____

CURRENT FEEDING STATUS

Briefly, what are your concerns regarding your child's feeding development/skills? _____

When did you first become concerned about your child's eating? _____

What made you concerned? _____

How is your child currently being fed?

☐G-tube ☐ NG-tube ☐J tube ☐NJ tube ☐Mouth

Bolus Schedule: _____

Does your child show signs of hunger? ☐ Yes ☐ No How does your child let you know he/she is hungry?:

_____

Length of typical mealtime? _____

Feeding environment: ☐high chair ☐table ☐walk around ☐other: _____

Are feeding times stressful? ☐ Yes ☐ No ☐Sometimes

Comments: _____

Currently drinks from (check all that apply):

☐bottle ☐breast ☐sippy cup ☐straw ☐open cup

Currently eats with (check all that apply): ☐spoon fed ☐hands ☐utensils ☐pouches

Does your child currently:

☐gag during/after feeding
☐food out of nose during or after eating
☐vomit during/after eating
☐frequently cough during/after feeding
☐choke during feeding
☐have a wet vocal quality during/after feeding

Please describe any other behaviors that are of concern (check all that may apply):

☐overstuffing mouth with food
☐refuses to eat
☐frequently drools
☐mouths objects/fingers
☐does not chew foods
☐pockets food in mouth
☐spills foods/drinks from mouth
☐difficulties using cup and/or straw
☐messy eater
☐picky eater
☐strong food preferences
☐avoids specific food textures/groups
☐avoids face washing
☐throws food
☐avoids being messy
☐refuses new foods
☐spits out food
☐grazes through the day
☐visible pain or discomfort while swallowing
☐strong flavor preferences
☐strong temperature preferences

Historically, child consumes adequate amount and variety of:

Liquids ☐ Yes ☐ No
Fruits ☐ Yes ☐ No
Vegetables ☐ Yes ☐ No
Grains ☐ Yes ☐ No
Dairy ☐ Yes ☐ No
Meats ☐ Yes ☐ No

What does your child eat on a "typical" day? *List specific foods and times*

Morning: _____

Noon: _____

Evening: _____

Overnight: _____

Please report cultural/religious preferences related to feeding: _____

_____