Children's Specialized Hospital Outpatient Center

Patient Questionnaire

As you go through this form, if you feel a particular section is not necessary for the purpose of serving your child, do not complete that section. Thank you.

Section I – Identifying Information

Child's Name_____ Birthdate _____/_____/_____ Sex_____

Diagnosis/Reason for visit:_____

Current School Placement

Name_____

Address_____

Classifaction_____ Last CST Evaluation_____

Current Therapies Received in School:

( ) Physical Therapy ____Yes ( ) _____No Frequency_____

( ) Occupational Therapy ____Yes ( ) _____No Frequency_____

( ) Speech Therapy ____Yes ( ) _____No Frequency_____

( ) Psychology ____Yes ( )_____No Frequency_____

List Current Physicians and Address

Pediatrician _____

Neurologist_____

Orthopedist_____

Other _____

How were you referred to Children's Specialized Hospital?
_____

Has your child been registered with NJ Special Health Services? Yes_____ No _____

If yes, when? _____ Case Manager _____

Current Medications

Name	Dose	Date Started

Allergies:

Medication_____Food/Other_____

Section II – Family Information

Mother _____ Birthdate _____

Father _____ Birthdate _____

Siblings and other household members:

Name	Relationship to Child	Age	Problem (if applicable)

Has anyone in the family (mother or father's side) had significant medical or emotional illness?

Yes_____ No____ If yes, please give details _____

_____

Section III – Maternal Pregnancy History

Times Pregnant _____ Miscarriages _____ Abortions _____

Health during pregnancy:

Illness _____ Accidents _____

Medication/Vitamins taken _____

Drugs/Alcohol/Smoking _____

Any other difficulties _____

Length of Pregnancy (full-term or premature) _____weeks or months

Labor & Delivery

Hospital _____ Length of Labor _____

Medication given (if applicable _____

Problems _____

Delivery: Normal _____ Induced _____C-Section _____ Problems during delivery _____

Birth weight _____ Length _____ Apgars _____

Neonatal Care:

Regular Nursery _____ Intensive Care Nursery _____

How old was the baby when he/she came home? _____

Jaundice Yes _____ No_____ Did the baby need lights? Yes _____ No _____

Did the baby: (Please answer yes or no)

Turn blue Yes _____ No _____

Have difficulty breathing Yes _____ No _____

Need a respirator Yes _____ No _____ How long? _____

Have a seizure Yes _____ No _____ Medication _____

Have muscle tremors Yes _____ No _____

Have bleeding in the brain Yes _____ No _____

Have surgery Yes _____ No _____ What kind? _____

Details on any of the above_____

_____

Section IV – Medical/Developmental History

Previous medical/therapy evaluations (Please list: type of evaluation, facility, and clinician or physician)

_____

_____

Previous therapy/treatment (Please list: type of evaluation, facility, and clinician or physician)

_____

_____

Operations/hospitalizations (Pleas list: dates, facility, and type of operation)

_____

_____

Serious illnesses/injuries/loss of consciousness (Please list dates and types)

_____

_____

Section V – Developmental Milestones

To the best of your memory, indicate what age your child accomplished each of the following or (if you do not remember the dates) please check if you child had difficulty achieving.

Motor Skills	**Age/ Difficulty**	**Speech and Feeding**	**Age/ Difficulty**
Held head up		Smiled	
Sat without support		Babbled	
Crawled on the floor		Played games:peek-a-boo ( ) patti-cake ( ) other ( )	
Stood alone		Words/phrases	
Transferred from hand to hand		Simple sentences	
Held bottle		Baby food	
Built blocks		Table food	

Motor Skills	Age/ Difficulty	Speech and Feeding	Age/ Difficulty
Used spoon ( ) fork ( ) cup ( )		Drank from cup	
Did buttons ( ) tied shoes ( )		Pointed to body parts	
Toilet trained		Recognized colors	
Dry at night		Recognized shapes	
		Recognized number	
		Recognized letters	

Section IV – Present Development

Medical problems (ear infections, seizures, allergies, etc) _____

_____

Vision: Good _____ Poor _____ Formally tested? Yes _____ No _____ Glasses? Yes _____ No ____

Hearing: Good _____ Poor _____ Formally tested? Yes _____ No _____ If yes, when? _____

Teeth: Good _____ Fair _____ Poor _____ Seen by a dentist? Yes ____ No ____ If yes, when? _____

Feeding difficulties _____ Sleeping difficulties _____ Toilet difficulties _____

Walking pattern: Normal _____ Abnormal _____ Coordination: Good _____ Fair _____ Poor _____

Describe details of any of the above: _____

_____

_____

Wears splint/braces: Yes _____ No _____ If yes, what kind? _____

Uses special equipment: ( ) wheelchair ( ) walker ( ) stander ( ) bath chair ( ) other_____

Talking pattern: (examples of speech) _____

_____

Behavior/Personality – Please check all that apply
Activity level: ( ) Quiet ( ) Average ( ) Overactive ( ) Hyperactive

( ) Cooperative ( )Self Confident ( ) Pays attention ( )Follows directions

( ) Understands what is said ( ) Generally happy ( ) Frustrates easily

( ) Other _____

How does your child interact with:

Siblings _____

Mother _____ Father _____

Other adults _____

Favorite activities: _____

_____

Dislikes _____

Fears _____

How do you discipline your child? _____

_____

What areas of behavior are harder for you to deal with? _____

_____

Does your child have difficulty separating from you? Yes _____ No _____

Is there anything else you would like us to know about your child? _____

_____

_____

_____

_____

_____ _____ _____

Signature Relationship to Child Date