CHILDREN'S SPECIALIZED HOSPITAL
PHYSIATRY
INITIAL INTAKE QUESTIONNAIRE

Directions: Please complete each section carefully (take note of sections requiring patient completion). If something does not apply, type "N/A" to ensure the question has not been overlooked. Completed questionnaires can be emailed to physiatry@childrens-specialized.org, faxed to (908) 301-5408, or mailed to Children's Specialized Hospital, 150 New Providence Road, Mountainside, NJ 07092, Attention: Lynn Rizkalla.

Date completed: **Completed by:**

GENERAL PATIENT INFORMATION		
Patient name: Preferred name *(if different than given name):*	Patient sex: ☐ Male ☐ Female	
Patient birthdate:	Patient age: Height: Weight:	
Patient racial/ethnic background:	☐ White/Caucasian	☐ Black/African-American
	☐ Hispanic-Latino	☐ Asian-American
☐ Native Hawaiian / Pacific Islander	☐ America Indian/Alaska Native	☐ Other
Please list all languages spoken in the home:		
Patient home address: City: State: Zip code:		
Patient phone #	Patient email:	
How did you hear about us?		

PATIENT'S BIRTH HISTYORY		
Prenatal Information		
Prenatal Care for Mother?	Pregnancy Complications?	
Medications During Pregnancy:		
☐ Prescribed	☐ Marijuana	☐ Hallucinogens
☐ OTC	☐ Opioids	☐ Other*:
☐ Alcohol	☐ Cocaine	*If yes, please list other medications
☐ Nicotine	☐ MDMA	
Perinatal Information		

Born at how many weeks gestation?	Birth Weight:
	Birth Length:

Postnatal Information		
NICU: Yes ☐ No ☐	If yes, how long was the NICU stay?	
Days in Hospital (if different than length of time in NICU)		
Ventilator: Yes ☐ No ☐	Hyperbilirubin: Yes ☐ No ☐	Phototherapy: Yes ☐ No ☐
Other Notes for Postnatal Information:		

PATIENT'S MEDICAL HISTORY & DIAGNOSES	
Physician's address: City: State: Zip code:	Specialty:
Phone #:	
E-mail address:	Fax #:
Reason for Visit:	
Diagnoses? Please list below.	

Family History

Please list all of the family members with the following diagnoses (i.e. mother, father, sister, brother, maternal/paternal grandmother or grandfather).

Cerebral Palsy:	Developmental Delay:
Stroke:	Intellectual Delay:
Muscular Dystrophy:	Low muscle tone:
Multiple Sclerosis:	Toe-walking:
Parkinson's Disease:	Other:
Genetic Syndrome:	

Diagnostic Testing

Head Ultrasound	Yes ☐ No ☐ If yes, list date
MRI	Yes ☐ No ☐ If yes, list date
CT	Yes ☐ No ☐ If yes, list date
Most recent hip/pelvis x-ray	Yes ☐ No ☐ If yes, list date
Spine x-ray	Yes ☐ No ☐ If yes, list date
Other x-rays	Please list with dates:
EEG	Yes ☐ No ☐ If yes, list date
Genetic Testing	Yes ☐ No ☐ If yes, list date
Gait/Movement Analysis Lab Study	Yes ☐ No ☐ If yes, list date

Vison Exam	Yes ☐ No ☐ If yes, list date
Hearing Exam	Yes ☐ No ☐ If yes, list date

Procedures/Surgeries

Previous Botulinim Toxin Injections or Alcohol/Phenol Nerve Blocks: Yes ☐ No ☐

Orthopedic Surgery: Yes ☐ No ☐

If yes, please list all orthopedic surgeries.

Neurosurgery, Baclofen Pump: Yes ☐ No ☐	*If yes, please answer the following questions.* Date of Implantation: Surgeon: Hospital: Catheter Tip Location: Dose/Rate: Who refills the pump?
Neurosurgery, Selective Dorsal Rhizotomy: Yes ☐ No ☐	*If yes, please answer the following questions.* Date of Surgery: Surgeon: Hospital:
Neurosurgery, Deep Brain Stimulator: Yes ☐ No ☐	*If yes, please answer the following questions.* Date of Surgery: Surgeon: Hospital: Who programs your device?

Other surgeries: Yes ☐ No ☐

If yes, please list all other surgeries.

PATIENT'S EXPERIENCE WITH THERAPIES

Early Intervention Therapies

Please check the box if your child is currently receiving or has in the past received the following:

☐ Physical Therapy

☐ Occupational Therapy

☐ Speech Therapy

☐ DI

☐ Other, please list

School-Based Therapies

Please check the box if your child is receiving or has in the past received the following:

☐ Physical Therapy

☐ Occupational Therapy

☐ Speech Therapy

☐ Behavioral

☐ Other, please list

Outpatient Therapies

Please check the box if your child is receiving or has in the past received the following:

☐ Physical Therapy

☐ Occupational Therapy

☐ Speech Therapy

☐ Behavioral

☐ Other, please list

Other Therapies

Please list any other relevant therapies.

PATIENT'S MEDICAL PROVIDERS

Pediatrician/Primary Care

Name:	Specialty:
Physician's address: City: State: Zip code:	
Phone #:	Fax #:

Physiatrist (Physical Medicine and Rehabilitation) Yes ☐ No ☐

Name:	Specialty:
Physician's address: City: State: Zip code:	
Phone #:	Fax #:

Orthopedist Yes ☐ No ☐

Name:	Specialty:
Physician's address: City: State: Zip code:	
Phone #:	Fax #:

Neurologist Yes ☐ No ☐

Name:	Specialty:
Physician's address: City: State: Zip code:	
Phone #:	Fax #:

Neurosurgeon Yes ☐ No ☐

Name:	Specialty:
Physician's address: City: State: Zip code:	
Phone #:	Fax #:
Pulmonologist Yes ☐ No ☐	
Name:	Specialty:
Physician's address: City: State: Zip Code:	
Phone #:	Fax #:
Phone #:	
Gastroenterologist Yes ☐ No ☐	
Name:	
Name:	
Physician's address: City: State: Zip Code:	
Phone #:	
Ophthalmologist Yes ☐ No ☐	
Name:	
Physician's address: City: State: Zip Code:	
Phone #:	
Urologist Yes ☐ No ☐	
Name:	
Physician's address: City: State: Zip Code:	
Phone #:	
Nephrologist Yes ☐ No ☐	
Name:	
Physician's address: City: State: Zip Code:	
Phone #:	
Cardiologist Yes ☐ No ☐	
Name:	
Physician's address: City: State: Zip Code:	
Phone #:	
Endocrinologist Yes ☐ No ☐	
Name:	
Physician's address:	

City:	State:	Zip Code:
Phone #:		
Geneticist Yes ☐ No ☐		
Name:		
Physician's address: City:	State:	Zip Code:
Phone #:		
Other Yes ☐ No ☐		
Name:		
Physician's address: City:	State:	Zip Code:
Phone #:		

MEDICATIONS & ALLERGIES

Medications

	Currently	Previously	Reason for discontinuation
Baclofen (Ozobax, Lioresal, Gablofen)	☐	☐	
Tizanidine (Zanaflex)	☐	☐	
Diazepam (Valium)	☐	☐	
Clonazepam (Klonopin)	☐	☐	
Lorazepam (Ativan)	☐	☐	
Dantrium (Dantrolene)	☐	☐	
Carbidopa-Levodopa (Sinemet)	☐	☐	
Bromocriptine (Parlodel, Cycloset)	☐	☐	
Trihexyphenidyl (Artane)	☐	☐	
Benztropine (Cogentin)	☐	☐	
Tetrabenazine (Xenazine)	☐	☐	

Allergies

Does your child have any allergies? Yes ☐ No ☐

If yes, please list all of your child's allergies below:

-
-
-
-

BRACING & MEDICAL EQUIPMENT NEEDS

Bracing

Does your child currently have braces? Yes ☐ No ☐ Please check all of your child's bracing needs. ☐ Arms/Hands ☐ Legs/Feet ☐ Trunk ☐ Head/Neck ☐ Other:	*If you **checked yes** to any of the boxes on the left, please answer the following.* Orthotist's Name: Address: City: State: Zip Code: Phone:
Medical Equipment	
Does your child have any medical equipment? Yes ☐ No ☐ Please check all of your child's medical equipment needs. ☐ Walker/Gait Trainer ☐ Stander ☐ Wheelchair/Adaptive Stroller ☐ Feeding/Activity Chair ☐ Lift (Hoyer) ☐ Specialized Bed ☐ Adaptive Bath Seat ☐ Adaptive Toileting System ☐ Adaptive Car Seat ☐ Communication Device ☐ Other:	*If you **checked yes** to any of the boxes on the left, please answer the following.* Medical Equipment Supplier's Name: Address: City: State: Zip Code: Phone:

SCHOOL		
Name and address of the patient's school:		
Current grade level of child:		
Has the patient repeated a grade?	☐ No	☐ Yes Grade:
Does the patient have an IEP?	☐ No	☐ Yes
Does the patient have a 504 Plan?	☐ No	☐ Yes
Current school scenario: ☐ Regular classroom ☐ Self-contained classroom ☐ Resource room ☐ Special school ☐ Home instruction ☐ Other:		
Current Accommodations:		

SOCIAL
Home Environment

Please check the box that most appropriately describes your child's living situation.

☐House ☐Apartment ☐Other:

How many steps does it take to enter the patient's home?

How many steps does it take to enter the patient's bathroom?

How many steps does it take to enter the patient's bedroom?

Does the patient have a handicapped parking permit? Yes ☐ No ☐

FUNCTION

Mobility

Which best describes your child? Check all that apply.

- ☐ Walking without assistance of bracing
- ☐ Walking with braces
- ☐ Walking with braces and/or walker
- ☐ Walking with braces and/or crutches
- ☐ Walking with gait trainer
- ☐ Pushes own wheelchair independently
- ☐ Drives power wheelchair independently
- ☐ Wheelchair pushed by someone else
- ☐ Stretcher only

Which best describes your child? Please check one.

- ☐ Walks without limitations
- ☐ Walks with limitations (e.g. difficulty with long distances, needs wheelchair or other mobility device for long distances in the community, needs railing to walk up and down stairs).
- ☐ Walks using a hand-held device indoors (e.g. crutches, cane, walker) and uses a wheelchair independently outdoors and in the community
- ☐ Walks with significant support (e.g. gait trainer) and/or uses a power wheelchair.
- ☐ Transported in a manual wheelchair or may have limited use of a power wheelchair.

Motor

Which best describes your child? Please check one.

- ☐ Handles objects easily and successfully. May need minimal assistance handling small, heavy or delicate objects.
- ☐ May need minimal assistance coordinating between hands.
- ☐ Handles most objects but with somewhat reduced quality and/or speed.
- ☐ Handles objects with difficulty. Needs help with setup or assistance with task. Needs additional time.
- ☐ Handles a limited selection of easily managed objects. Needs continuous help with tasks. Can participate meaningfully in only parts of an activity.
- ☐ Requires total assistance with all tasks using hands. May participate in simple movements.

Communication

Which best describes your child's communication? Please check all that apply.

- ☐ Speech
- ☐ Sounds (such as an "aaaah" to get a person's attention)
- ☐ Hand gestures or body movements
- ☐ Sign Language (e.g. American Sign Language)
- ☐ Communication book, board, and/or pictures
- ☐ Communication Device

Which best describes your child (using any method of communication)? Please check one.

- ☐ Communicates with familiar and unfamiliar people without difficulty
- ☐ Communicates effectively but at a slower pace
- ☐ Communicates effectively with only familiar people
- ☐ Communicates with familiar people but is inconsistent in expressing their thoughts and/or understanding the other person
- ☐ Unable to communicate

Feeding

Which best describes your child?

- ☐ Feeds self independently
- ☐ Feeds self with assistance
- ☐ Fed by parent or caregiver
- ☐ Feeding Tube (NGT, GT, JT)

Which best describes your child? Please check one.

- ☐ Eats and drinks safely and efficiently in same time as peers
- ☐ Eats and drinks safely but takes longer than peers
- ☐ Eats and drinks with some limitations to safety (difficulty biting and chewing hard lumps of food with risk of choking)
- ☐ Eats and drinks with significant limitations to safety (has risk of aspiration (choking) but risk can be managed with equipment or techniques)
- ☐ Unable to each or drink safely (tube feeding)

Please describe your child's typical diet/formula.

Other Activities of Daily Living

Please check the box that most describes your child's daily activity level.

Dressing	☐ Independent	☐ Requires Assistance	☐ Dependent
Bathing	☐ Independent	☐ Requires Assistance	☐ Dependent
Toileting	☐ Independent	☐ Requires Assistance	☐ Dependent
Transfers	☐ Independent	☐ Requires Assistance	☐ Dependent

Please check all that apply to your child.

☐ Bowl Incontinence ☐ Bowl Continence

☐ Bladder Incontinence ☐ Bladder Continence

SPORTS & RECREATION

Please check off any sports and recreational activities your child participates in.

- ☐ Regular Physical Education
- ☐ Adaptive Physical Education
- ☐ Individual Sports
- ☐ Adaptive Individual Sports
- ☐ Team Sports
- ☐ Adaptive Team Sports
- ☐ Swimming
- ☐ Other recreational activities
- ☐ Bicycle/Tricycle