CHOOSE THE HOME TEAM CYPRESS CREEK THERAPY

Pediatric Patient Questionnaire

Patient Name: _____ Date of Birth: _____

Height: Feet: ____ Inches: _____ Weight: _____

Referring Physician:_____ Primary Physician:_____

REASON FOR VISIT
CHIEF COMPLAINT

Please briefly describe the reason for this visit:

When did the problem begin (date) Month_____ Year _____

Please rate the severity of your pain/symptoms by circling the appropriate number on a scale of 0 to 10 with 0 being no pain/symptoms and 10 being severe pain/symptoms

Pain at worst: 0 1 2 3 4 5 6 7 8 9 10

Pain at best: 0 1 2 3 4 5 6 7 8 9 10

Pain on average: 0 1 2 3 4 5 6 7 8 9 10

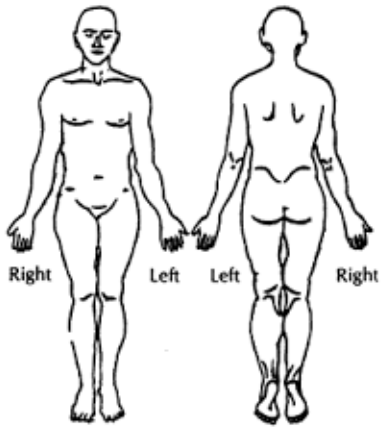
When is it the worst? (Please circle all that apply):
Morning Evening Constant Standing Sitting Walking Driving
Other_____

What makes the problem better?_____

How would you describe you symptoms (please circle all that apply): Aching Burning Dull Sharp Numbness Tingling Throbbing Spasms Tightness

Other:_____

Please shade area(s) on diagram below the location of you problem/pain:



Medical History	Please check ***all*** illnesses or conditions which apply to your child: ☐ Anemia ☐ Diabetes ☐ Kidney Disease ☐ Asthma ☐ Mental Illness ☐ Kidney Stones ☐ Arthritis ☐ Emphysema ☐ Liver Disease ☐ Bleeding/Blood Disorder ☐ Epilepsy/seizures ☐ Multiple Sclerosis ☐ Cancer(s)_____ ☐ Fibromyalgia ☐ Osteoporosis ☐ Cataracts ☐ Glaucoma ☐ Rheumatic Fever ☐ Chronic fatigue syndrome ☐ Heart disease ☐ Thyroid disease ☐ Chronic pain syndrome ☐ Hepatitis/jaundice ☐TMJ/jaw problems ☐ Colitis ☐ High Blood Pressure ☐ Tuberculosis ☐ Depression ☐ HIV/AIDS ☐ Ulcers ☐ Other(s): _____ Is your child up to date with all vaccinations? ☐ Yes ☐ No; explain: _____ _____
Trauma & Serious Injuries	Please list below any *prior* serious injuries your child has sustained and their approximate dates: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____
Surgeries Hospitalizations	Please list any *prior* surgeries with approximate date(s): 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____
Recent Tests	Please list below any recent tests your child had had. (ex. Xray, MRI, nerve conduction study) 1. _____ DATE_____ 2. _____ DATE_____ 3. _____ DATE_____ 4. _____ DATE_____
Allergies	Is your child allergic to tape? ☐ Yes ☐ No Is your child allergic to latex? ☐ Yes ☐ No Please list any other allergies: _____

Medications	Please list ***all*** medications your child is currently taking including any herbal medications, vitamins or supplements: (Include: name, dose, frequency, and route of intake) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____ 9. _____ 10. _____
Pregnancy History:	Please describe pregnancy history including any complications: _____ _____ _____
Birth History:	Please describe child's birth history (vaginal, caesarean, weeks born, complications, etc): _____ _____ _____
Developmental Milestones:	Age when child performed the following developmental milestones: 1. Rolling: _____ 2. Sitting: _____ 3. Crawling on hands and knees:_____ 4. Walking: _____ 5. Jumping: _____ 6. Talking: _____
Education:	Please list child's current school and grade level: School:_____ Grade Level:_____ Is your child currently on an IEP or 540? ☐ Yes ☐ No
Additional Therapy:	Please list any other therapies/ services your child receives currently, or has received in the past: _____ _____ _____ _____

Communication:	If your child is nonverbal, what type of communication device or explain how your child communicates with others (i.e. sign language, gestures, etc.)? _____ _____ _____ _____
Behavior:	Does your child exhibit any behaviors? If yes, what are typical triggers for their behaviors, and what does your child respond best to in order to deescalate? ☐ No ☐ Yes _____ _____ _____ _____
Medical Equipment:	Please list any and all medical equipment that your child currently uses (i.e. walker, braces, shower chair): _____ _____ _____ _____
Limitations:	Please list your main area of concern for your child: _____ _____ _____ _____ _____
Goals:	Please list your main goal(s) for your child: _____ _____ _____ _____ _____
Additional Comments:	Please include any additional comments that would be helpful for your child's therapist to get to know him/ her (i.e. motivators, interests, etc.): _____ _____ _____ _____

Review of Symptoms	Please review the following list of symptoms and check ***all*** that apply to your child: ***Head and Neck Symptoms:*** ☐ Visual changes (not glasses) ☐ Double vision ☐ Dizziness ☐ Vertigo ☐ Sinus problems ☐ Ear pain ☐ Trouble hearing ☐ Ringing in the ear ☐ TMJ or jaw pain ***Musculoskeletal Symptoms:*** ☐ Joint pain ☐ Back pain ☐ Neck pain ☐ Shoulder pain ☐ Arm pain ☐ Leg pain ☐ Foot pain ☐ Ankle pain ☐ Elbow pain ☐ Weakness in arms/legs ☐ Joint swelling or stiffness ☐ Scoliosis ***Neurologic Symptoms:*** ☐ Numbness or tingling ☐ Severe and/or frequent headaches ☐ Abnormal coordination ☐ Trouble with speech ☐ Forgetfulness ☐ Confusion ***Heart/Vascular Symptoms:*** ☐ Chest pain or pressure ☐ Irregular rapid heart beat