Official Use Only:
Diagnosis Code(s):__________
____
____

Magnolia Pediatric Therapy
Parent Questionnaire

Please complete ALL items below:

Patient Information

Today's Date: ___________________________________

Patient's Name: _________________________________

Patient's Date of Birth: ___________________________

School and Grade: _________________________________

Preschool /Daycare: ______________________________

Primary Care Physician: ____________________________

Guardian/Sponsor Information

Name: ____ Work Phone: ___________________________

Address: ______________________________________ Home Phone: ___________________________

City: __________________________State: _____Zip:___________ Cell Phone: ______________________________

Name: ____ Work Phone: ___________________________

Address: ______________________________________ Home Phone: ___________________________

City:__________________________State:______Zip:__________ Cell Phone: ______________________________

Email address (es): ____

Preferred method of communication (circle all that apply): EMAIL TEXT PHONE: home cell work

Please list names, ages and relationships of persons living in the home with the child:

Siblings: ____

Other: ____

Is there a language other than English spoken in the home? ☐ Yes ☐ No If yes, which one?____________________

Does the child understand the language? ☐ Yes ☐ No Does the child speak the language? ☐ Yes ☐ No

Background Information

☐ Full Term Pregnancy ☐ Premature Birth

Length of Pregnancy (weeks): _________________ Birth Weight: ________________ Birth Length: _________________

☐ Normal Delivery ☐ Cesarean ☐ Other ____

Medications Used During Pregnancy: ____

Complications During Pregnancy/Delivery: ____

Childhood Hospitalizations, Illnesses, and/or Surgeries

Age: _______________________ Reason: ____

Age: _______________________ Reason: ____

Age: _______________________ Reason: ____

Age: _______________________ Reason: ____

Does your child take medications? ☐ Yes ☐ No

If yes, which ones?

____

____

Does your child have allergies (to include latex)? ☐ Yes ☐ No

If yes, which ones?

____

Date of last: Hearing Screening: ______________________________ *Please circle one*: PASSED FAILED

Vision Screening: ______________________________ *Please circle one:* PASSED FAILED

Is there a History of Ear Infections? ☐ Never ☐ Occasional ☐ Frequent ☐ Chronic (persisting for a long time)

Current Main Mode of Speech/Communication ☐ Gestures ☐ Vocalizations ☐ Using Words ☐ Device

If using words, please rate the skill: ☐ Age appropriate ☐ Delayed ☐ Impaired

Has your child ever been tested for an inability to sit still, pay attention, remember things, or learn like other children his/her age? ☐ Yes ☐ No If yes, has a formal diagnosis been given? ☐ ADD ☐ ADHD ☐ Autism ☐ Other:__________

If no, do you have any concerns in any of these areas? ☐ Yes ☐ No

If yes, please explain: ____

(If School age) Does your child have any learning disabilities? ☐ Yes ☐ No

If yes, please explain: ____

Please let us know when you child accomplished the following developmental milestones

Holding Head Up	Age:	Not Applicable
Babbling	Age:	Not Applicable
Rolling Over	Age:	Not Applicable
Sitting Up	Age:	Not Applicable
First Word	Age:	Not Applicable
Pulling Up to Stand	Age:	Not Applicable
Crawling	Age:	Not Applicable
Walking	Age:	Not Applicable

Are you concerned with your child's eating/drinking habits? ☐ Yes ☐ No

If yes please answer the following:

Would you consider your child a "picky" eater? ☐ Yes ☐ No

Does your child ever cough/choke when eating/drinking? ☐ Yes ☐ No

Does your child ever sound gurgly while eating/drinking or immediately after? ☐ Yes ☐ No

Does/Did your child use/eat the following: (please circle)

Breast	Yes	No	Age:	
Bottle	Yes	No	Age:	
No-Spill Cup	Yes	No	Age:	
Straw	Yes	No	Age:	
Open Cup	Yes	No	Age:	
Other	Yes	No	Age:	
Fruits	Yes	No	Age:	Frequency:
Vegetables	Yes	No	Age:	Frequency:
Grains	Yes	No	Age:	Frequency:
Dairy	Yes	No	Age:	Frequency:
Meats	Yes	No	Age:	Frequency:

On a scale of 1 to 4, how does your child function in the following areas? (circle one)

1= Completely dependent on others. Significant concerns in this area.

2= Needs a lot of help or cues. Moderate concerns in this area

3= Needs some help or cues. Mild concerns in this area.

4= Completely independent. No concerns in this area

Dressing	1	2	3	4	Not Applicable
Toileting	1	2	3	4	Not Applicable
Eating (Breast or Bottle)	1	2	3	4	Not Applicable
Eating (Soft foods off spoon)	1	2	3	4	Not Applicable
Eating (With fingers)	1	2	3	4	Not Applicable
Eating (With Utensils)	1	2	3	4	Not Applicable
Sippy Cup	1	2	3	4	Not Applicable
Drinking from a Cup	1	2	3	4	Not Applicable
Playing with Peers	1	2	3	4	Not Applicable
Handwriting	1	2	3	4	Not Applicable
Hearing	1	2	3	4	Not Applicable
Climbing Stairs	1	2	3	4	Not Applicable
Frustration Tolerance	1	2	3	4	Not Applicable
Sleeping Routine	1	2	3	4	Not Applicable
Grooming	1	2	3	4	Not Applicable
Maintaining Attention to Tasks	1	2	3	4	Not Applicable
Entertaining Self	1	2	3	4	Not Applicable
Climbing (Ex: Playground Equipment)	1	2	3	4	Not Applicable
Hand/Eye Coordination	1	2	3	4	Not Applicable
Balance	1	2	3	4	Not Applicable
Following Verbal Directions	1	2	3	4	Not Applicable
Communicating Wants and Needs	1	2	3	4	Not Applicable
Safety Awareness	1	2	3	4	Not Applicable

Has your child ever had other therapies in the past? ☐Yes ☐No

If yes, please describe: ____

Does your child currently attend other therapies? ☐Yes ☐No

If yes, please describe: ____

Does your child use a pacifier now or have they ever used one? ☐ Yes ☐ No If yes, how often?____________________

Please list your child's strength's:____

____

Please list your child's needs/weaknesses: ____

____

Please let us know your child's favorite things:

Food: ______________________________________ Drink: ____

Snack: _____________________________________ Candy: _______________________________________

Toy: _______________________________________ Game: ____

TV Show/Movie: ____________________________ Activity: ______________________________________

Other Favorites: ____

Please list objects, activities, foods, places, etc. that your child DOES NOT like: _______________________________

____

____

Please list any other concerns or information that you feel we need to know about your child: ___________________________

____

____

____

____

____

____

____

____

Thank you for filling out the information above, it will help us get to know your child better. If you could please provide copies of results of previous testing, screenings, and swallow studies as soon as possible we would greatly appreciate it.

If you have any questions please let us know.