Please list any days/ time slots you **CANNOT** attend appointments :

# New Patient Questionnaire

Date: _____

Child's Name: _____ Child's DOB: _____

Parent/Guardian Name: _____ Relationship: _____

Phone/Contact Information:

Home: _____ Cell: _____

Do you accept cell phone texts: YES or No Email:_____

Address: _____City: _____

Emergency Contact Name/Relationship: _____

Phone: _____

Referring Primary Care Physician: _____ Phone: _____

Medical Diagnosis (if any): _____

Specialists working with your child:

Specialty: _____

Phone: _____

Specialty: _____

Phone: _____

Reasons for Referral (Please describe your main concerns):

_____

_____

Please list any services you child is receiving (PT, ST, OT, Behavioral Interventionist):

_____

How did you hear about Happy Hands Therapy Services:_____

**Health History**

What was the length of the pregnancy? _____

Were there any illnesses or difficulties during the pregnancy or birth? If so, please explain.

_____

_____

_____

Has your child been hospitalized for any reason since birth? If so, why? _____

_____

_____

Has your child ever had a hearing screening? If so, when and what were the results? _____

_____

_____

Has your child ever had a vision screening? If so, when and what were the results? _____

_____

_____

Does your child wear glasses? YES or NO

_____

**Medical History**

Please circle if your child has had any of the following:

| | | | |
|---|---|---|---|
| Seizures | High fevers | Measles | Mumps |
| Chicken pox | Whooping cough | Diphtheria | Croup |
| Pneumonia | Tonsillitis | Meningitis | Encephalitis |
| Rheumatic fever | Tuberculosis | Sinusitis | Chronic colds |
| Enlarged glands | Thyroid | Heart problems | Asthma |

Ear infections Other significant illness (list)_____

_____

Allergies: _____

_____

Current medications: _____

_____

Are immunizations up to date? YES or NO
(If no please explain)_____

_____

_____

**Developmental History**

Indicate the approximate age your child attained their milestones, if you can't remember specific time, please indicate if it occurred at the expected range (N for normal) or if it was delayed.

Sat up alone _____ Crawled_____ Pulled to stand _____

Walked _____ Toilet trained _____

Please circle the appropriate selection below:

Does your child show a preference for being: Left handed Right handed Undetermined

Describe your child's attention span: Poor Average Great

Describe your child's sleeping pattern: <6 hours 7-10 hours 10+ hours

Does your child have difficulty with falling/staying asleep Yes No

Describe your child's eating: Poor Average Great

*(Poor- eats from limited number of foods, Average- has preferred foods from a variety of food groups, Great- eats a variety from all food groups)

How well he/she plays with other children: Average Has difficulty Does not play with other kids

Can he/she throw and catch a ball: Yes No

Can he/she ride a trike/bike (with or without training wheels): Yes No

Can he/she climb playground equipment Yes No

Please list if your child is involved in any sports/physical activities such as soccer, T-ball, dance, play groups etc:_____
_____

Does your child show any unusual behaviors (if so, please explain)? _____
_____

Any motor or developmental issues in the immediate or extended family? (If yes, please explain):
_____
_____

Please place a check mark in the appropriate box for each skill:

| Skill | Requires lots of help/ cannot do task at all | Requires some help (specify which parts) | Can do the skill without help |
|---|---|---|---|
| Eat without spilling using a fork | | | |
| Eat without spilling using a spoon | | | |
| Opening Food packages (such as chips, yogurt or pudding) | | | |
| Uses/ hold scissors appropriately | | | |
| Uses/ holds pencil/crayon appropriately | | | |
| Putting on pants (including zipper and button) | | | |
| Putting on t-shirt | | | |
| Putting on and tying tennis Shoes (not Velcro) | | | |
| Can initiate and zip up jacket | | | |
| Can brush hair/ put hair into ponytail | | | |
| Brushes teeth | | | |
| Toileting: can clean self after | | | |
| Bathing | | | |

**Language Development**

Do you feel your child speaks the appropriate amount for his/her age? _____

_____

Does your child have any trouble understanding you? _____

_____

Does your child have difficulty following directions? _____

_____

Do you have difficulty understanding your child's speech? _____

_____

Any speech or hearing problems in the immediate or extended family (If yes, please explain):

_____

_____

_____

**Social Development**

Who lives in the home with your child? (parents, siblings, grandparents etc?) _____

_____

Siblings/Ages: _____

_____

Number of regular playmates: (indicate age): _____

_____

How does your child handle:
Frustration: _____

_____

Separation:_____
Social Situations: _____

_____

Favorite places: people: toys: _____

_____

What motivates your child the most? _____

_____

_____

**Daycare/School History**

Is your child attending a daycare, preschool or school? If so please list school and current grade?

_____

_____

Is your child in regular education, 504 accommodations or special education? _____

_____

How does your child's teacher describe his/her performance? And please list any teacher concerns or areas of difficulties.

_____

_____

Is your child willing to try something new? _____

Does your child cope well with transitions? _____

Does your child need specific routines? _____

Anything else you would like us to know? _____

_____

_____

List your goals or outcomes for therapy: _____