

Courage Center Pediatric Health History Questionnaire

12400 Portland Ave S, Ste 140
Burnsville, MN 55337
952.898.5700

146 North Lake Street, Ste 100
Forest Lake, MN 55025
651.464.5235

3915 Golden Valley Road
Minneapolis, MN 55422
763.588.0811

1460 Curve Crest Blvd
Stillwater, MN 55082
651.439.8283

Child's last name: _____ **First name:** _____ **MI:** _____

Birthdate: _____ **Medical diagnosis:** _____

Current age: _____ **Phone number:** _____

Caregiver/sibling names: _____

What is the primary reason you are seeking therapy services?

How well do you speak English? Fluently English understood Interpreter needed
If not English, what is your native language?

Birth history: Gestation: _____ Birth weight: _____

- | | | |
|--|---|---|
| <input type="checkbox"/> Normal birth, no concerns | <input type="checkbox"/> Anoxia | <input type="checkbox"/> CMV |
| <input type="checkbox"/> Prematurity | <input type="checkbox"/> Fetal distress | <input type="checkbox"/> Low Apgar scores |
| <input type="checkbox"/> Meconium aspiration | <input type="checkbox"/> Prenatal exposure to | <input type="checkbox"/> Adopted/medical |
| <input type="checkbox"/> Other pertinent birth problems: | drugs, alcohol or toxins | history unknown |

Medical history: Has your child ever had any of the following?

- | | | |
|--|---|---|
| <input type="checkbox"/> Difficulty with hearing | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Behavior concerns |
| <input type="checkbox"/> Wears hearing aids | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sensory concerns |
| <input type="checkbox"/> Difficulty with vision | <input type="checkbox"/> Cancer | <input type="checkbox"/> Uses a manual wheelchair |
| <input type="checkbox"/> Wears glasses | <input type="checkbox"/> Asthma | <input type="checkbox"/> Uses a power wheelchair |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Shunt | <input type="checkbox"/> Uses a cane or walker |
| <input type="checkbox"/> Breathing problems | <input type="checkbox"/> Cleft lip/palate | <input type="checkbox"/> Ear infections #___/PE tubes |
| <input type="checkbox"/> Broken bones | <input type="checkbox"/> Feeding problems | <input type="checkbox"/> wears orthotics or splints |

Allergies: food/other/latex: _____

Surgeries/hospitalizations: _____

Current medications:

Are there any treatment precautions?

Special diet: Yes No If yes, what type: _____

Developmental history: Was your child delayed in acquiring any of the following milestones?

- Roll
- Babble/coo
- Drinks from cup
- Sit
- Uses words
- Finger feeds
- Stand
- Uses 2 word phrases
- Uses utensils
- Walk
- Toilet trained

How does your child communicate?

- Gestures
- Words
- Uses augmentative system
- Sounds
- Sign language
- Uses PECS or picture symbols

With whom does your child live?

- Mom
- Foster parents
- Group home setting
- Dad
- Siblings
- Other:
- Both/two parents
- Other relatives

Does your home have:

- Stairs, no railing
- Ramp
- Bathtub
- Stairs, with railing
- Elevator
- Shower

Does your child participate in any of the following:

- Daycare
- Head Start
- Pre-school
- Public school
- Private school
- Home school
- Early childhood/ family education
- Early childhood/ special education
- Uses personal care attendant/nanny
- Other:

School services:

Child's school: _____ Grade level: _____

City/school district: _____

Has your child ever been evaluated by your school district: Yes No

If yes, when: _____ reasons: _____

Does your child currently have an IEP, EFSP or IIIIP? Yes No *(If yes, please bring a copy of the education plan to your appointment so we can coordinate with your child's school program.)*

Please list the services your child receives through the public schools:

- | | How often (days per week or time per session): | Individual or group setting: | Name of school staff: |
|---|--|------------------------------|-----------------------|
| <input type="checkbox"/> Occupational therapy | | | |
| <input type="checkbox"/> Physical therapy | | | |
| <input type="checkbox"/> Speech therapy | | | |
| <input type="checkbox"/> Psychologist | | | |
| <input type="checkbox"/> Social Worker | | | |
| <input type="checkbox"/> Other: | | | |

Other services: Has your child received or is currently receiving services from another provider?

Name of provider:

Last visit:

- Occupational therapy
- Physical therapy
- Speech therapy
- Psychology/mental health counselor
- Neurologist
- Orthopedist
- Psychiatrist
- Chiropractor/osteopath
- Other:

Social/emotional history:

Prefers to play: Alone With other children With adults

Preferred toys/activities:

Toys/activities child is afraid of:

Separation from parent: Easily separates Resistant to separate, calms quickly
 Resistant to separate, cannot calm

Behavior concerns:

Difficulty with sleeping:

Overly sensitive to things in the environment:

Comfort level in water: Afraid Not afraid

What is important for the therapists to know about your child and family?

What would you or your child hope to accomplish with therapy?

After discharge from therapies, do you plan that your child will remain in his/her current living situation? Yes No If no, is there anything you would like your child's therapist to address with you prior to discharge?

Is there any additional information you want to share? (For example--cultural or spiritual beliefs that affect care, legal considerations, or health considerations or directives)

Form completed by _____

Relationship to client _____ **Date** _____