10932 Old Denton Road
Suite 108
Fort Worth, TX 76244
Phone: 817-975-4696
Fax: 817-796-2781

PATIENT QUESTIONNAIRE

PATIENT INFORMATION

Name: _____ Date: _____

Sex: ☐ Male ☐ Female Birthdate: _____ Age: _____

BIRTH HISTORY

Was child born full term? _____ If not, how many weeks? _____

Were there any complications at birth? _____

_____

Did the child spend any time in the NICU? If so, how long? _____

Did the child require oxygen? _____ For how long? _____

Length of time in the hospital: _____

MEDICAL INFORMATION

Medical diagnoses: _____

_____

Does the patient have any allergies? _____

Primary care doctor: _____

Referring doctor: _____

Specialists seen: _____

Hospitalizations/Surgeries: _____

_____

_____

Equipment: _____

_____

THERAPY SPECIFIC INFORMATION

At what age did your child roll? _____ Sit alone? _____

Crawl? _____ Walk? _____

Say first word? _____ Put 2 words together? _____

Does your child wear glasses? _____ Vision issues? _____

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PATIENT QUESTIONNAIRE

Does your child have any hearing issues? _____
Does your child startle easily? _____
What kind of food does your child eat? ☐Puree ☐Soft textures ☐Finger food ☐Tube fed
Does your child refuse to eat any foods? _____
Is your child's language understood by: parents? _____ Siblings? _____
Teachers? _____ Peers? _____

OTHER

Is your child in school? _____ What grade? _____
Name of school _____
Does your child receive therapy in school? _____
Name of therapist(s) _____
Is your child in a mainstream classroom? _____
Does your child have trouble with reading? _____ Handwriting? _____
Does your child receive any other therapy at this time? _____
If so, what disciplines and with whom? _____
_____

TELL US A FEW OF HIS/HER FAVORITES

Favorite color: _____
Favorite character: _____
Favorite toy: _____
Favorite food: _____
Favorite candy: _____