Middlesex Health
Physical Rehabilitation

Mayer Center
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Caregiver Pediatric Therapy Evaluation Questionnaire

The purpose of this questionnaire is to provide background information about your child and to express any concerns for developmental skills. Some questions may not apply to every child, but we ask that you fill this out to the best of your ability and avoid leaving sections blank. Feel free to write in the margins or provide any additional information within the comment sections as you complete this questionnaire. Thank-you!

Demographic and Family Information

Child's Name: ______________________________ Date of Birth: ______________ Age: ________

Caregivers' Names: ______________________________ Relationship to Child: ______________________________

______________________________ ______________________________

Reason for seeking therapy: ______________________________

Areas of Concern/Goals

When did you first have concerns about your child?

____

What strategies or techniques have you been trying independently? ______________________________

____

What specific skills would you like your child to achieve in therapy? ______________________________

____

Pain Scale: Rate your pain today (Circle): **(No Pain) 0—1—2—3—4—5—6—7—8—9—10 (Worst Pain)**

Pregnancy and Birth History

Any complications for mother or baby during pregnancy? ❑ Yes ❑ No (If Yes, please specify below)
❑ Gestational Diabetes ❑ Pre-eclampsia ❑ Disorder of Placenta ❑ High-risk Pregnancy
❑ Intrauterine Growth Restriction (IUGR) ❑ Pre-existing Conditions (ex. cardiovascular disease) ❑ Other, please explain:

____

Was the delivery:
❑ Vaginal ❑ C-Section ❑ Induced

Any complications with labor or delivery? ❑ Yes ❑ No (If Yes, please specify below)
❑ Low APGAR scores ❑ Prolonged delivery ❑ Meconium aspiration ❑ Breeched ❑Low oxygen ❑ Abnormal heart rate for baby ❑ Nuchal Cord (umbilical cord wrapped) ❑ Use of vacuum/forceps ❑ Preterm ❑ Low birth weight
❑ Other, please explain: ______________________________

____

Any concerns or interventions following birth? ❑ Yes ❑ No (If Yes, please specify below)
❑ Need for Oxygen ❑ Seizures ❑ NICU, length of stay? __________ ❑ Jaundice ❑ NG or G/feeding tube placed
❑ Special Care Nursery ❑ Congenital Abnormalities ❑ Genetic Testing ❑ Small for Gestational Age (SGA)
❑ Other, please explain: ______________________________

____

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Child's Name: ____ Date of Birth: _______________

Medical History

Have you seen your Pediatrician for:
❑ Routine visit or physical ❑ General illness (i.e., flu-like symptoms, cold, congestion, fever, etc.) ❑ Respiratory Illness
❑ Ear infections ❑ Feeding concerns, vomiting, weight checks/gain or reflux ❑ Other (please explain): _________________

____

Does your child have any allergies? ❑ Yes ❑ No
If yes, please list ALL known allergies (i.e., seasonal, latex, peanuts, medications etc.): ______________________________

____

Does your child take any medications or supplements? ❑ Yes ❑ No
If yes, please list all medications/supplements and dosages: ____

____

Is your child followed by any specialists? ❑ Yes ❑ No
Please list/name any specialists and locations:

❑ Developmental Pediatrician: ________________________________
❑ Cardiologist: ____
❑ Neurologist: ____
❑ Gastroenterologist: ______________________________________
❑ Otolaryngologist (ENT): __________________________________
❑ Allergist: ____
❑ Genetics: ____
❑ Feeding Team: ____
❑ Orthopedic: ____
❑ Audiology: ____
❑ Vision specialist: _______________________________________
❑ Other: ____

Has your child received a formal diagnosis by a medical professional? ❑ Yes ❑ No (If Yes, please specify below)
❑ Autism Spectrum Disorder ❑ Down Syndrome ❑ Traumatic Brain Injury ❑ Concussion ❑ Developmental Delay
❑ Cerebral Palsy ❑ Hearing Loss ❑ Asthma ❑ Seizures ❑ Genetic Disorder ❑ Learning Disability ❑ CHARGE
❑ Other, please explain: ____

Has your child ever been evaluated and/ or received Early Intervention Services/Birth to 3? ❑ Yes ❑ No

Please check any/all services your child receives or has received in the past:
❑ Developmental specialist; how often? ____________
❑ Speech-Language Pathologist; how often? ____________
❑ Physical Therapist; how often? ____________
❑ Occupational Therapist; how often? ____________
❑ Other: _________________________________; how often? ____________

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Physical Development

Any concerns regarding gross motor skills (i.e., walking up/down stairs, running smoothly, jumping)? ❑ Yes ❑ No

If yes, please explain: ____

Any concerns regarding fine motor skills (i.e., stacking blocks, drawing, cutting, writing, feeding, dressing)? ❑ Yes ❑ No

If yes, please explain: ____

Any concerns regarding speech and language skills (i.e. articulation, social communication, understanding and following directions, feeding, expressing needs and wants)?

If yes, please explain: ____

Any concerns regarding daily living skills (i.e. dressing, bathing, toileting, feeding, navigating their environment, sleeping)?

If yes, please explain: ____

Educational and Social History

Does your child attend school or daycare? Please provide the following information:

School/Daycare: ____________________ Location: ____________________ Grade /Level: __________

Has your child's teacher or providers shared any concerns regarding Speech, Language, Social Engagement, Motor Skills, Self Regulation, Daily Living Skills? ❑ Yes ❑ No

Comments:____

Has your child been evaluated for Services through your local public school? ❑ Yes ❑ No ❑ In process of evaluating

Does your child have an Individual Education Plan (IEP)? ❑ Yes ❑ No ❑ Not currently, but in the past and when? __________

____

Does your child have a 504 Plan? ❑ Yes ❑ No ❑ Not currently, but in the past

If yes, what accommodations or modifications are in place? ____

____

If yes, what services does/did your child receive:

❑ Speech/Language Therapy ❑ Physical Therapy ❑ Occupational Therapy ❑ Applied Behavioral Analysis (ABA) ❑ Vision
❑ Assistive Technology/AAC ❑ Social Skills ❑ Other: ____

Does your child have a Behavior Plan? ❑ Yes ❑ No ❑ Not currently, but in the past

Do you have any concerns about your child's attention? ❑ Yes ❑ No

If yes, please explain: ____

____

Do you have any concerns about your child's behavior(s)? ❑ Yes ❑ No

If yes, please explain: ____

____

How does your child play?

❑ Prefers to play alone ❑ Prefers to play with adults ❑ Plays mostly with siblings ❑ Plays with a lot of friends/enjoys groups
❑ Plays cooperatively ❑ Requires encouragement to play with others

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Child's Name: ____ Date of Birth: _______________

How would you describe your child (reserved, outgoing, energetic, playful, etc.)?

____

____

What are some of your child's favorite activities and/or toys?

____

____

How does your child transition from one activity or location to another or separating from parents? _______________________

____

Please describe your child's strengths or areas you are proud of: ____

____

Goals and Consent

At the end of my first visit, my therapist and I will discuss treatment options for my child, including risks, benefits, and plans for treatment. I understand that my therapist and I will work together to meet these goals. **I agree (Initial each section below):**

- _______ To keep all of my child's appointments, or call at least 24 hours in advance if we need to cancel. If we miss two appointments in a row without calling to cancel, our name will be taken out of the schedule, and we may need a new doctor's referral to continue therapy.
- _______ If we are late for an appointment, the therapist will determine if there is enough time in the schedule to see my child.
- _______ We may receive care from another therapist if our therapist is unavailable.
- _______ To implement strategies and activities into my child's day per therapist recommendations.
- _______ Tell my child's therapist if he/she has any changes in health and/or medication, or if they see another doctor for the same condition.
- _______ My child's therapy will end when he/she has met their goals or when my child's therapist determines my child has reached the highest possible benefit of therapy. Therapy can also end due to a change in my child's health, lack of insurance, or if we stopped coming for treatment.
- _______ It is my responsibility to check my insurance coverage for Outpatient Hospital/Facility-based Therapy Services.
- _______ To stay on the premises during my child's therapy session.

____ _______________ ____________
Patient/Guardian Signature **Date** **Time**

____ _______________ ____________
Therapist Signature **Date** **Time**