Follow Up History Questionnaire

Child's name:______________________________
Current Age:_________________________

Dear Parent/Guardian:
Please answer the following questions as best you can and return it to us before your appointment. We want to know what continuing or new concerns you have since your last visit so we can best plan the appropriate developmental/ academic testing and gather the appropriate information from you and your child's school in order to best evaluate your child.

If your child has had recent evaluations or an updated IEP since your last visit, please also send those to us before the appointment.
For Elementary/Middle School children please bring a copy of your child's last report card if available.

Please answer the following questions and give examples where relevant:

Do you have ongoing or new concerns regarding your child language or motor development? –Yes / No
If yes please explain;____
____

Do you have ongoing or new concerns about your child's behavior at home or in school such as hyperactivity, defiance, poor social skills? –Yes/ no
If yes please explain;____
____

Do you have ongoing or new concerns about your child's school performance in reading, writing or math? Yes / No
If yes please explain;____
____

Other concerns: ____

MEDICAL HISTORY
Please list any new medical concerns, hospitalizations or surgeries with dates.
____
____
____

Is your child currently taking medications? Yes No

If so, please list medications and any side effects:_________________________
____
____

Does your child have known/new allergies to food or medications? Yes No
If yes, please list:____

If your child is under school age;
What therapies are they currently receiving, please specify EI, CPSE, Private.

____
____
____

If your child is in School/Preschool what school does he/she attend and in what grade?

____
____

What therapies/supports does your child currently receive in school? ________

____
____
____

What therapies you're your child receive outside of school?

____
____
____

Please add any specific concerns or questions you would like us to review at this appointment.

____
____
____

If your child is **under 5 years** of age please complete the following:

My child feeds him/herself with fingers	Yes	No	Sometimes
My child feeds him/herself with utensils	Yes	No	Sometimes
My child can drink from an open cup	Yes	No	Sometimes
My child can wash his/her hands and face	Yes	No	Sometimes
My child can brush his/her teeth	Yes	No	Sometimes
My child can undress him/herself	Yes	No	Sometimes
My child can dress him/herself	Yes	No	Sometimes
My child performs simple household chores	Yes	No	Sometimes
My child plays appropriately with toys	Yes	No	Sometimes
My child can play independently	Yes	No	Sometimes
My child shares his/her toys well	Yes	No	Sometimes
My child enjoys playing with other children	Yes	No	Sometimes
My child asks for friends by name	Yes	No	Sometimes
My child can play a turn taking game	Yes	No	Sometimes
My child enjoys playing dress up	Yes	No	Sometimes
My child comes to greet me when I come home	Yes	No	Sometimes
My child shows separation anxiety when I leave	Yes	No	Sometimes
My child spontaneously expresses affection	Yes	No	Sometimes
My child comforts other children in distress	Yes	No	Sometimes
My child shows pride in his/her accomplishments	Yes	No	Sometimes
My child brings me toys and books to share	Yes	No	Sometimes
My child will ask for help if needed	Yes	No	Sometimes
My child will say please and thank you	Yes	No	Sometimes
My child follows directions	Yes	No	Sometimes
My child responds when I call his name	Yes	No	Sometimes
My child uses gestures to communicate	Yes	No	Sometimes
My child uses words to communicate	Yes	No	Sometimes
My child uses sentences to communicate	Yes	No	Sometimes
My child asks questions	Yes	No	Sometimes

My child uses the following # of words < 5, 5 to 20 , 20 to 50 , More than I can count

My child walks well	Yes	No	Sometimes
My child can walk up and down stairs	Yes	No	Sometimes
My child runs well	Yes	No	Sometimes
My child will play ball games	Yes	No	Sometimes
My child participates in team games	Yes	No	Sometimes
My child can scribble	Yes	No	Sometimes
My child can draw a recognizable figure	Yes	No	Sometimes
My child can write his/her name	Yes	No	Sometimes

We are dedicated to improving patient care for children who may have unique challenges in hospital and clinic settings. If you feel that your child has special needs in this area, please complete the form below based on your past experience in hospital/medical settings. Your feedback can help us to improve the care of all our patients.
During medical visits, does your child have an unusual amount of distress or difficulty with any of the following?

Please check your answer in the boxes below and comment if your answer is YES.
If YES, choose 1= sometimes, 2= often, 3= very often

	NO	YES	1	2	3	Please describe
Waiting in the waiting room						

Vitals and Exam

	NO	YES	1	2	3	Please describe
Weight						
Height						
Blood pressure						
Physical exam						

Physical environment in medical settings;

	NO	YES	1	2	3	Please describe
Florescent lights						
Noises sounds of monitors etc.						
Number of people in the room						
Someone in a white coat						
Exam table and or medical equipment						

Please share with us any ways in which you think we can make medical office and hospital visits less stressful for your child.

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