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PHYSICAL THERAPY

Pediatric Bowel/Bladder Intake Questionnaire

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

Parent/Guardian Name:_____

Reason for Referral:_____

_____

Child was born: Full-term_____ or Premature_____; If premature, how many weeks?_____

Delivery: Vaginal_____ C-section_____ Birth Weight:_____ Breast fed:____ Bottle fed:____

Any complications at birth?_____

_____

Developmental History: Please indicate the age at which your child achieved the following milestones. Mark N/A for the which your child skipped or has not yet achieved.

Rolled over_____ Sat alone_____
Crawled_____ Pulled to stand_____
Stood alone_____ Toilet trained_____
Walked alone_____ Dressed self_____
Was child placed on belly as an infant? Yes No Did they enjoy tummy time? Yes No

Current physical limitations:_____

Comments:_____

Medical History:
Current diagnosis:_____

Hospitalizations: No Yes; If yes, please describe:_____

_____

Surgeries: No Yes; if yes, please list_____

Medications:_____

Special equipment your child uses: Spints Braces Other:_____

Any feeding problems or nutritional concerns?_____

_____

Please circle all that apply to your child:

Trach	Allergies	Hearing Aids	Wears glasses
C-Line	Latex sensitivity	Hearing difficulty	Vision problem

Comments:_____

Caregiver Concerns

What are your main concerns with your child?_____

_____

Has your child received physical, occupational or speech therapy in the past? Yes No
If yes, please indicate which services and for how long:_____

_____

Educational Information

School/Educational program currently attending:_____

Present grade level:_____

Special services received in the school: OT PT Speech

Behavior - Please check any of the following that apply to your child:

Cries often	Dislikes playground equipment
Frequent temper tantrums	Anxious
Trouble following directions	Clumsy
Weak muscles	Picky eater

What are your goals or what outcomes do you hope for with therapy in our clinic?_____

_____

_____

Thank you for the time to fill out this questionnaire. This information will help us to become more familiar with your child so we can provide the best service possible to you and your child.

Signature:_____ Date:_____

Patient Name:_____