Pediatric Development Center
Of Atlanta, LLC
Occupational and Speech Therapy

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Parent Questionnaire

Date:_____

Child's Name:_____ Birth date:_____
Parent/Guardian Name(s):_____
Physician:_____ Physician Phone Number: _____
Home Address:_____
Home phone:_____ Work:_____ Cell:_____
Email address:_____
Referred by or how learned of PDCA: _____
Guarantor (Medicaid/Insurance):_____
Siblings names/ages: _____

Birth History
Birth weight:_____ Birth height:_____ Length of Pregnancy (weeks):_____
Type of delivery:_____
Complications at birth for baby:_____
Treatment received by baby or mother:_____

Postnatal History
Please describe any important illnesses, injuries or surgeries, including colic, ear or chest infections, etc. and the ages at which they occurred: _____
_____
_____
_____
_____

Current medical diagnoses/conditions: (ADHD, Autism, asthma, LD, etc.): _____
_____
Current medications: _____
Allergies:_____
Dietary restrictions:_____

Developmental History
At what age (in months) did your child?: sit alone:_____ creep/crawl:_____
pull to stand:_____ walk alone:_____ babble: _____say first word:_____
say 2 word phrases: _____ toilet train: _____
What languages are spoken in the home?: _____
Were there any unusual observations during the development of these skills, such as dislike of being on their stomach, not crawling on hands and knees, scooting on their bottom, not responding to sounds, not making sounds to gain attention etc?:
_____
_____
_____

Have you noticed any differences compared to your other children or peers?: _____
_____
_____
_____

Are there any family/living situations which you think might affect your child's development or therapy?:
_____
_____

Are there any eating concerns (picky eater, avoidance of food textures or tastes, drooling, poor control of food in mouth)?:
_____
_____

Is your child currently receiving any therapy or involved in any special programs?: _____
_____
_____

What other evaluations, therapy or special programs has your child had in the past and when?:_____
_____
_____

Family History
Is there any immediate family history of the following (please list who and explain)?:
Premature birth: _____
Delay in speech/motor skills: _____
Learning disabilities:_____
Medical diagnoses (i.e. Autism, ADHD, genetic disorders, mental health issues, etc): _____
_____

Concerns
Please describe your concerns about your child, citing specific areas (motor weaknesses, behaviors, academic difficulty, frustrations, self-help skills, peer relations, eating, etc.)
_____
_____
_____
_____

What would you like us to help you and your child with?: _____
_____
_____
_____

What are your goals for your child?: _____
_____
_____

Completed by: _____ Signature: _____