KINETIC KIDS, INCORPORATED
Occupational Therapy, Physical Therapy,
Speech Language Pathology and Consulting Services
2051 NW 112th Ave #125, Miami, FL 33172-1835
Phone: 305-878-0083 **Fax**: 305-477-7808
Email: awildac@kinetickidstherapy.com, jenniferg@kinetickidstherapy.com

CHILD/FAMILY QUESTIONNAIRE

Name of Child_____ Sex_____ Date of Birth_____

Home Telephone_____ Place of Birth_____

Home Address _____ City_____ Zip Code_____

Name of Parent or Guardian with whom child lives_____

FAMILY MEMBERS (Please circle and fill in questions)

Mother's Name_____ Age _____

Mother's Occupation_____ Home Phone_____

Work Place_____ Cell Phone_____

Email Address_____ Fax_____

Father's Name _____ Age _____

Father's Occupation_____ Home Phone_____

Work Place_____ Cell Phone_____

Email Address_____ Fax_____

Are there any major medical conditions for mother or father? _____ if yes, explain _____

_____

_____

What language(s) is/are spoken in the home? _____

What adults live in the child's home? _____

List names and ages of all children in the present family_____

_____

Do any live in another home? If yes, with whom? _____

_____

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Are any children in special education? _____

Do they have any other problems? _____

MOTHER'S PREGNANCY (for this child only)

Were you under a physician's care? _____ did you take any medications or drugs? _____

Did you smoke? _____ How much?_____

Did you drink beer, wine, or alcohol? **Yes or No**. If yes, how much?
_____

Did you have any problems during pregnancy? **Yes or No**. If yes, please explain._____

_____

Was the birth full term or premature? If premature, what month? _____

Was the delivery **Normal** or **Caesarian section**? _____

Did you or the baby have any problems before, during, or after birth? **Yes** or **No**. If yes, explain.
_____

_____

DEVELOPMENTAL HISTORY

Birth Weight: _____lbs._____oz.

At what age did she/he sit alone? _____ At what age did he/she walk? _____

At what age was toilet training completed? _____ Is he/she a bed wetter? _____

When did she/he say first word? _____ When did he/she use sentences? _____

Can other individuals understand him/her clearly? _____

When did your child self-feed with spoon? _____

MEDICAL HISTORY

Physician Name:_____Number:_____Fax: _____

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Diagnosis Relevant for Therapy: _____

Has your child been hospitalized? _____ If yes, when? _____

For what reason? _____

Has s/he had any operations as an outclient? _____ If yes, explain_____

Does your child have seizures? **Yes** or **No**. Has your child had any major illness? **Yes** or **No**.

If yes, explain._____

_____

Does your child take daily medications? **Yes** or **No** If yes, please provide name, dosage, and reason for taking medication._____

_____

Does your child require special equipment, such as a wheelchair, braces, etc? **Yes** or **No.** If yes, explain

_____

_____

Does your child have ear or hearing problems? **Yes** or **No**. If yes, explain._____

_____

Does your child have eye problems? **Yes** or **No** If yes, explain._____

_____

Does your child have any special condition not yet mentioned? **Yes** or **No**. If yes,

Explain._____

_____

Is your child receiving **speech therapy**, **physical therapy**, or **occupational therapy**?

If yes, please provide therapy services, providers, contact numbers and length of time in therapy and days of service at present? _____

_____

_____

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EDUCATION HISTORY

Is your child attending a day care, nursery, or school program? _____ If yes,

where?_____Phone:_____

Has your child attended any other programs before? _____ When? _____

Where? _____ Phone: _____

Are there any problems your child has had in either of the above program(s)? _____

_____

Can your child separate easily from you? _____

How do you feel your child learns best? _____

CURRENT FUNCTIONING

What is your child's favorite activity at home? _____

How long is s/he able to attend to one activity? _____

Does s/he have any chores? **Yes** or **No.** If yes, what are they? _____

Does s/he have difficulty getting along with any family members? **Yes** or **No** If yes, explain._____

_____

Does your child follow simple directions? **Yes** or **No** If yes, give an example._____

How do you discipline your child? _____

Does it work? _____

What things cause your child to cry? _____

What things make your child happy? _____

Do you feel your child may have behavioral/emotional problems? **Yes** or **No.** If yes, please describe:

_____

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Can your child become physically aggressive in the form of hitting, biting, scratching or other injurious behaviors to self or others? **Yes** or **No**.

When did this problem start? _____

Is your child able to verbally communicate with you? _____

If not, are alternative forms of communication used? _____

PARENTS' COMMENTS

How would you describe your child? _____

_____

Are there any other problems or conditions not mentioned above that you feel should be shared?
_____

_____

Do you have any other questions or concerns about your child? **Yes** or **No**. If yes, please explain

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

This questionnaire was completed by: _____

On (date) _____ Relationship to this child_____