



4900 Massachusetts Ave NW, Suite 340 Washington, DC 20016
(202) 621-9793 • Care@TriumphTherapeutics.com

Child's name: _____ Child's preferred name: _____

DOB: _____

Parent/Guardian(s) name(s): _____

Phone number(s): _____

Child's primary physician: _____ Phone: _____

Other medical providers: _____ Phone: _____

What are your main concerns for your child at this time?

Birth and Medical History

Any pertinent family medical history? _____

Has your child had any medical difficulties/complications?

Does your child have any medical diagnoses?

Has your child had any recent injuries?

Has your child had any significant illnesses, surgeries or hospitalizations? If yes, please describe.



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Prenatal History

Were there any complications, illnesses or stressors during the pregnancy or birth? Yes No

Type of delivery: Vaginal Cesarean Birth weight _____

Pre-term (< 37 weeks): Yes No If yes, how many weeks: _____

Was your child placed in the Newborn Intensive Care Unit (NICU)? Yes No

If yes, how long? _____

Any feeding or breathing support provided while in the NICU? _____

Developmental History

Please describe any concerns you noted in your child's development:

At what age did your child begin to:

Roll: _____ Crawl: _____ Sit: _____

Pull to stand: _____ Walk: _____

Health Conditions

Please check any condition your child has now or has had in the past :

- | | |
|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Upper respiratory infections |
| <input type="checkbox"/> Behavior Problems | <input type="checkbox"/> Hearing or visual impairment |
| <input type="checkbox"/> Chronic diarrhea | <input type="checkbox"/> Nervous tics or Tourette's |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Birth or congenital malformation |
| <input type="checkbox"/> Drooling | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Fluid in ears | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Multiple ear infections (3 or more) | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Other: _____ |



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Has your child had any imaging or special testing performed? Yes No If yes, please describe.

Is your child on any medications? Yes No

Does your child have any special equipment or orthotics? Yes (mark below) No

Wheelchair

Crutches

Communication device

Braces/orthotics

Hearing aids

Other: _____

Walker

Eyeglasses

Has your child received any occupational therapy, physical therapy or speech therapy before including early intervention and school based? Yes No If yes, please describe.

Occupational Therapy

Is your child able to dress themselves independently? Yes No

Do they have difficulties with fasteners, such as buttons, zippers etc.? Yes No

Are they able to hold a writing utensil (crayon, pencil, marker etc.) to write, color, or draw?

Yes No

Are they able to hold scissors to cut paper? Yes No

About how long is your child able to sit at a table and focus on a task, such as coloring, writing, or mealtime? If in school, about how long are they able to remain seated and focused in class?



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Does your child have any sensory issues, such as with sounds, textures, smells etc.? If so, how do they respond to this input (ex. Covering ears when loud ambulance siren is heard)?

Does your child have any feeding or eating difficulties that cause you concern, such as refusal to eat certain textures etc.? Yes No If yes, please describe

Social History

Who does the child live with? Please provide name(s) and age(s) of any siblings at home.

Child's favorite activities?

What are your child's strengths?

What upsets your child?

Is your child involved in extracurricular activities? Yes No Please list:



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What are you and your child's goals for therapy?

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

Signature: _____ Date: _____

Name printed: _____

Patient Name _____