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 :

☐ Allergies
☐ Behavior Problems
☐ Chronic diarrhea
☐ Constipation
☐ Eczema
☐ Drooling
☐ Fluid in ears
☐ Multiple ear infections (3 or more)
☐ Seizures
☐ Upper respiratory infections
☐ Hearing or visual impairment
☐ Nervous tics or Tourette's
☐ Asthma
☐ Birth or congenital malformation
☐ Diabetes
☐ Heart disease
☐ Cancer
☐ 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
- ☐ Braces/orthotics
- ☐ Walker
- ☐ Crutches
- ☐ Hearing aids
- ☐ Eyeglasses
- ☐ Communication device
- ☐ Other: _____

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.

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?

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

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 _____