Rady Children's Hospital San Diego

Rady Children's Hospital – San Diego
3020 Children's Way
San Diego, CA 92123-4282

DTR1394

PATIENT INFORMATION

Name: ______________________
MR#: ____________ Finance: ________
DOB: ______________________
MD: ______________________

Occupational Therapy/Physical Therapy Orthopedic History Questionnaire

IDENTIFICATION

PATIENT'S NAME	BIRTH DATE	SEX ☐ MALE ☐ FEMALE	AGE

PATIENT'S PRIMARY CARE PHYSICIAN

PERSON COMPLETING THIS FORM	DATE

RELATIONSHIP TO PATIENT

STATEMENT OF THE PROBLEM

Describe as completely as possible the reason for referral/concern:

When was the problem first noticed?

What do you feel are some reasons for this problem?

Has the patient received help for this problem? If so, what type?

Where?	When?

GENERAL

What is the primary language spoken by patient? ____________ What other languages are spoken in the home? ____________

By whom are they spoken and how often? ____________

Have there been any recent significant stress-producing events? ☐ Yes ☐ No For whom? ☐ Parent ☐ Patient If yes, explain:

MEDICAL HISTORY

Is the patient under the care of a doctor(s)? ☐ Yes ☐ No	Who?	Why?	
Are immunizations up-to-date? ☐ Yes ☐ No			
Is the patient in pain? ☐ Yes ☐ No	If yes, please explain:		
Is the patient taking medication? ☐ Yes ☐ No	Type(s)?	Why?	
Is the patient taking herbs? ☐ Yes ☐ No	Type(s)?	Why?	
Do you think hearing is normal? ☐ Yes ☐ No	Has hearing ever been tested?	☐ Yes ☐ No	If so, when?
Where?	Results		
Do you think the patient's vision is normal? ☐ Yes ☐ No	Are glasses worn?	☐ Yes ☐ No	

Do you think the patient's nutritional needs are being met? ☐ Yes ☐ No Explain:

At what age did the following occur? Please explain.

	N/A	AGE	EXPLAIN		N/A	AGE	EXPLAIN
Allergies				Heart Problems			
Asthma				Meningitis			
Blood Disease				Muscle Disorder			
Chronic Colds				Nerve Disorder			
Dental Problems				Seizures			
Diabetes				Other			
Eye Problem							

Has the patient ever been diagnosed with:

X		BY WHOM	WHEN	DO YOU AGREE? Yes	No
	Autism				
	Cerebral Palsy				
	Developmental Problem				
	Down Syndrome				
	Eating Disorder				
	Fine Motor Problem				
	Gross Motor Problem				
	Head Injury				
	Hearing Loss				
	Learning Problem				
	Mental Retardation				
	Neurological Problem				
	Speech and/or Language Problem				
	Visual Impairment				
	Other (Specify)				

Mark any evaluations or therapy received. If received by the patient, mark a “P”; if received by another family member, mark an “F”.

_______ Speech-Language
_______ Physical
_______ Parent Training
_______ Occupational
_______ Hearing
_______ Educational
_______ Behavioral
_______ Counseling
_______ Developmental
_______ Psychological
_______ Nutritional

Describe the results:

___

___

___

SOCIAL/BEHAVIOR

Check these if they apply to the patient:

______ Aggressiveness
______ Biting
______ Under active
______ Over active
______ Separation difficulties
______ Difficulty getting along with others
______ Lives in a world of his/her own
______ Difficulty staying with an activity
______ Injures self
______ Prefers to play alone
______ Difficult to discipline
______ Overly sensitive

Describe any behavior that is a problem: ___

___

___

EDUCATIONAL HISTORY

School now attending: ___ **Grade:** ___

☐ Regular Education ☐ Special Education ☐ Therapy Services ☐ In-home Program

Does the patient remember homework instructions? ___

Does the patient follow directions? ___

Does the patient retain information taught? ___

What is your impression of the patient’s learning abilities? ___

What would the patient and/or you like to accomplish through this assessment process? ___

___

___

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