PAIN AND SLEEP
Therapy Center

# PEDIATRIC HEALTH QUESTIONNAIRE (PHQ)

*This questionnaire has been compiled from multiple sources in order to gather information and identify concerns with the pediatric patient's overall growth and health.*

**REASON FOR CONSULTATION (What results are you seeking from treatment?)**

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

## PATIENT DEMOGRAPHICS

First Name:_________________ Middle Initial:_____ Last Name:____________________
Gender: ___________ Date of Birth: _____________ Height: __ft __in Weight: ____lbs
Address: _____________________________ Address 2: _____________________________
City: ____________________________ State:____ Zip Code:__________

## PARENT/CAREGIVER CONTACT INFORMATION

Parent/Guardian Full Name: _________________________ Relationship to Patient: ________
Home/Cell Phone: _____________________ Work Phone: _____________________
Email: ___________________________________________
Please provide names and ages of other members in the household (including pets):

______________________________________________________________________________

______________________________________________________________________________

## PROVIDER INFORMATION

**REFFERAL SOURCE:** ____________________

*Dental Provider Office:*_______________________ Last Visit: ______________________
Dentist Name:_______________________ Office Phone:______________________
City:____________________ State:____________ Zip Code: ___________________

*Pediatrician's Office*: _______________________ Last Visit: ______________________
Doctor Name: ______________________ Office Phone:______________________
City: ____________________ State:____________ Zip Code: ___________________
Any concerns/red flags: _____________________________________________________

*Providers/Specialists (if applicable)*:_______________________ Last Visit: ______________
Doctor Name:_______________________ Office Phone:______________________
City:____________________ State:____________ Zip Code: ___________________

*Providers/Specialists (if applicable)*: _______________________ Last Visit: ______________
Doctor Name:_______________________ Office Phone:______________________
City:____________________ State:____________ Zip Code: ___________________

**PREGNANCY/BIRTH HISTORY:**

If your child was adopted, please answer the following questions to the best of your knowledge.

# of weeks gestation at birth:______ Vaginal or c-section: ________________

Birth Weight:___lb.___ oz

How are/did you feed your baby (breast/bottle/both): ________________________________

Please list any feeding concerns (gas, reflux, colic symptoms, gagging, etc.):

_____________________________________________________________________________

Did your child pass the newborn hearing screening: YES or NO ___

Frequent ear infections: YES or NO ___ PE tubes: YES or NO ___

Please describe any health problems that the mother or infant experienced during pregnancy or following birth:___________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

**DEVELOPMENTAL HISTORY**

| | CONCERNS |
|---|---|
| Gross motor (rolling, sitting, crawling, walking) | |
| Fine motor (grasping, toy manipulation, self-help skills, utensils) | |
| Oral-Motor/Feeding (chewing, swallowing, self-feeding) | |
| Speech/Language (vocalizing/talking, listening, vocabulary) | |
| Cognition/Play (attention, thinking, problem solving) | |
| Social/Emotional (peer interaction, behavior) | |

Please list any therapy services your child has previously received or is currently receiving:

_____________________________________________________________________________

_____________________________________________________________________________

**MEDICAL HISTORY**

Does your child have any allergies to medications or other irritants? (pets, plants, food, etc.)______

*If YES, please list (including rash, hives, throat swelling, anaphylaxis reactions).*

| **ALLERGY** | **REACTION** |
|---|---|
| | |
| | |
| | |
| | |
| | |

Please list ALL current medications (including over-the-counter, supplements & herbs):

| **MEDICATION/REASON** | **DOSE** |
|---|---|
| | |
| | |
| | |
| | |

Has your child EVER experienced any of the following? (place an “X” next to ALL that apply):

| Condition | | Condition | |
|---|---|---|---|
| Anemia/Bleeding tendency | | Ear/Nose/Throat problems | |
| Asthma/Breathing problems | | Eczema/Skin disorders | |
| Behavioral problems | | Eye disorder | |
| Blood transfusion | | Growth disorder | |
| Bowel/Stomach problems | | Heart disorder/defect | |
| Cancer/Leukemia | | Kidney/bladder problems | |
| Chicken Pox/Shingles | | Liver disease | |
| Developmental disorder | | Seizure or Epilepsy | |
| Diabetes | | Thyroid disorder | |
| Plagiocephaly/Brachycephaly | | Vision Problems | |
| Torticollis | | | |

Please list any other medical illnesses or problems and provide details for any of the above conditions: ______________________________________________________________

______________________________________________________________

Please indicate any major conditions/illnesses that immediate family members have had: __________

______________________________________________________________

______________________________________________________________

**PAST SURGICAL HISTORY**

| Procedure | | | | | | |
|---|---|---|---|---|---|---|
| Previous lip or tongue released | Yes | | No | | At what age? | |
| Tonsils removed | Yes | | No | | At what age? | |
| Adenoids removed | Yes | | No | | At what age? | |
| Ear tubes placed | Yes | | No | | At what age? | |

Please list any surgeries (including age when surgery was performed):__________________________

______________________________________________________________

______________________________________________________________

Please list other procedures/treatments (include age when performed):__________________________

______________________________________________________________

______________________________________________________________

**DENTAL/STRUCTURAL**

| Condition | | | | |
|---|---|---|---|---|
| Crooked/Crowded Teeth | Yes | | No | |
| Tooth Decay | Yes | | No | |
| Red Inflamed Gums (Gingivitis) | Yes | | No | |
| Bad Breath (Halitosis) | Yes | | No | |
| Difficulty with teeth brushing | Yes | | No | |
| “Gummy” smile | Yes | | No | |
| TMJ (jaw joint) pain | Yes | | No | |
| Neck or shoulder pain | Yes | | No | |
| Headaches or migraines | Yes | | No | |

Please elaborate on any concerns (listed above):______________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

**BREATHING (*If no concerns, skip to the next section.)***

| | | | | | | |
|---|---|---|---|---|---|---|
| Mouth open or breathing through mouth during the day | Never | | Sometimes | | Often | |
| Congestion (Nose, Ears, Chest, Etc) | Never | | Sometimes | | Often | |
| Difficulty breathing through nose | Never | | Sometimes | | Often | |
| Sinus problems | Never | | Sometimes | | Often | |
| Bronchitis or cough | Never | | Sometimes | | Often | |
| Colds or flus | Never | | Sometimes | | Often | |

**SLEEP (*If no concerns, skip to the next section.)***

| | | | | |
|---|---|---|---|---|
| Does your child have a regular bedtime? | Yes | | No | |
| Does your child sleep in their own bed? | Yes | | No | |
| Is there an adult present when your child falls asleep? | Yes | | No | |
| Does your child have difficulty falling asleep? | Yes | | No | |
| Does your child awaken during the night? | Yes | | No | |
| If awakened, does your child have difficulty returning to sleep? | Yes | | No | |
| Does your child sleep in “strange” positions? | Yes | | No | |
| Is your child a poor sleeper? | Yes | | No | |
| Does your child alternate between households? | Yes | | No | |

| | | | | | | |
|---|---|---|---|---|---|---|
| Heavy (audible) breathing during sleep | Never | | Sometimes | | Often | |
| Gasping or stops breathing (sleep apnea) during sleep | Never | | Sometimes | | Often | |
| Snoring | Never | | Sometimes | | Often | |
| Restless Sleep (moving or kicking) | Never | | Sometimes | | Often | |
| Sweating when sleeping | Never | | Sometimes | | Often | |
| Nightmares | Never | | Sometimes | | Often | |
| Sleepwalking | Never | | Sometimes | | Often | |
| Sleep Talking | Never | | Sometimes | | Often | |
| Screaming during sleep | Never | | Sometimes | | Often | |
| Leg kicking during sleep | Never | | Sometimes | | Often | |
| Waking up at night | Never | | Sometimes | | Often | |
| Getting out of bed at night | Never | | Sometimes | | Often | |
| Waking up tired and not refreshed | Never | | Sometimes | | Often | |
| Sleeping with mouth open | Never | | Sometimes | | Often | |
| Resistance going to bed | Never | | Sometimes | | Often | |
| Grinding Teeth | Never | | Sometimes | | Often | |
| Uncomfortable, “creepy-crawly” feeling in legs | Never | | Sometimes | | Often | |
| Wetting bed | Never | | Sometimes | | Often | |

Please elaborate on any specific breathing or sleep concerns (listed above):____________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

**FEEDING (*If no concerns, skip to the next section.)***

| Nursing or bottle-feeding issues as a newborn | Never | | Sometimes | | Often | |
|---|---|---|---|---|---|---|
| Sensitive gag reflex | Never | | Sometimes | | Often | |
| Coughing, choking or gagging during eating or drinking | Never | | Sometimes | | Often | |
| Difficulty managing solids | Never | | Sometimes | | Often | |
| Limited food repertoire or picky eater | Never | | Sometimes | | Often | |
| Poor appetite | Never | | Sometimes | | Often | |
| Poor growth or overall nutrition | Never | | Sometimes | | Often | |
| Fast or messy eater | Never | | Sometimes | | Often | |
| Packs food in mouth (like a chipmunk) | Never | | Sometimes | | Often | |
| Slow eater | Never | | Sometimes | | Often | |
| Doesn't finish meals | Never | | Sometimes | | Often | |
| Mouthing of toys and objects | Never | | Sometimes | | Often | |
| Constipation/diarrhea | Never | | Sometimes | | Often | |

Please elaborate on any specific feeding concerns (listed above):______________________________

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**SPEECH & LANGUAGE (*If no concerns, skip to the next section.)***

| Difficulty pronouncing words | Never | | Sometimes | | Often | |
|---|---|---|---|---|---|---|
| Difficulty being understood by familiar listeners | Never | | Sometimes | | Often | |
| Difficulty being understood by unfamiliar listeners | Never | | Sometimes | | Often | |
| Frequently stutters or mumbles | Never | | Sometimes | | Often | |
| Difficulty getting words out (groping) | Never | | Sometimes | | Often | |
| Difficulty speaking at an adequate rate and rhythm | Never | | Sometimes | | Often | |
| Difficulty understanding what others say | Never | | Sometimes | | Often | |
| Difficulty responding | Never | | Sometimes | | Often | |
| History of speech delay/therapy? | Never | | Sometimes | | Often | |

Please elaborate on any specific speech and language concerns (listed above):__________________

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______________________________________________________________________________

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**BEHAVIOR (*If no concerns, skip to the next section.)***

| Oral habits (thumb/finger sucking, pacifier use, biting) | Never | | Sometimes | | Often | |
|---|---|---|---|---|---|---|
| Concerns with attention (hyperactivity or inattentiveness) | Never | | Sometimes | | Often | |
| Concerns with behavior | Never | | Sometimes | | Often | |
| Diagnosis (ADHD, ODD, PDD) | Never | | Sometimes | | Often | |

Please elaborate on any specific behavior concerns (listed above):______________________________

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______________________________________________________________________________

______________________________________________________________________________

What else would you like us to know about your child?________________________________________
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________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
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*We can't wait to meet you and be a part of your journey to optimal health and wellness for your child!*