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: _____
Parent/Guardian Full Name: _____ Relationship to Patient: _____
Occupation:_____ Occupation: _____
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:_____ Birth Weight:___lb.___ oz

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:_____

_____

Did the child stay in the NICU? YES or NO If yes, why:_____

_____

During Pregnancy did you experience any of the following:

Gestational Diabetes		Fetal Problems	
Urinary Tract Infection		Preterm Labor	
Preeclampsia		Varicose Veins	
Hyperemesis Gravidarum		Vaginal Thrush	
Placenta Previa		Polycystic Ovary Syndrome	
Infections		Autoimmune Disorder	
Sleep Apnea		Blood Disorder	
UARS (Upper Airway Resistance Syndrome)		Anemia	
Peripartum Cardiomyopathy		Headache/Migraine	
Hemorrhoids		Insomnia	
Depression		Breathing Problems	
Anxiety		Blocked Nose	
Heartburn		Other	

During The Birth Process did you experience any of the following:

Natural (no medications)		Challenging or Prolonged birth	
Vaginal		Forceps or Vacuum used at birth	
C-section		Pitocin used to induce labor	
Epidural used during labor and delivery		Umbilical cord wrapped around baby's neck	
Baby was breeched (Feet First)		Baby was turned transverse (sideways)	
C-Section was planned for convenience		C-Section was planned for repeat because mother had on prior	
C-Section was planned due to emergency		C-Section was planned due to failure to progress) baby wasn't coming down birth canal)	
C-Section was planned due to concerns about mother delivering vaginally			

How was your baby feed:

Breast		Bottle	
Breast and Bottle		Donated Breast Milk	
Syringe Feed		Feeding Tube	

As an infant did they experience any of the following while feeding (0 months -1 year):

Poor latch		Reflux	
Colic symptoms		Gagging	
Choking		Mouth Breathing	
Frequent Colds		Frequent Ear Infections	
Ear Tubes		Gas	
Difficulty Transitioning to Solids		Trouble gaining	

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):

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

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

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):_____

_____

_____

_____

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):_____

_____

_____

_____

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):_____

_____

_____

_____

What else would you like us to know about your child?_____

_____

_____

_____

_____

_____

_____

We can't wait to meet you and be a part of your journey to optimal health and wellness for your child!

Provider Use Only:

Upper Labial Classification: _____
Upper Labial Description: _____
_____

Lingual Classification: _____
Lingual Description: _____
_____

Recommend: _____
_____
_____
_____
_____
_____
_____
_____
_____