CHILDREN'S HOSPITAL
SUB-SPECIALISTS
OF CENTRAL TEXAS
A member of the
SETON Healthcare Network

Developmental Clinic

Patient Questionnaire
Follow-Up

Date: _____

Patient Name:	**DOB:**
Parent/Guardian:	**Date of Visit:**

Since the last visit are there any new medical Diagnoses, Hospitalizations, or Surgeries:
_____
_____

Any new Medications? _____

Any updates in your Family History? _____

Current School? _____

Any changes in your household? _____

Any recent Lab Work or Tests ? _____

Are you currently receiving therapies?☐YES☐NO (if yes, what therapies, where and at what frequency, i.e.2X/WK)
ST_____
OT _____
PT _____
Feeding _____
Behavioral_____
Other _____

Has your child had an evaluation in the last 6 months? ☐ Yes ☐ No
By whom?: ☐ECI ☐PT ☐OT ☐ ST ☐ABA ☐School

Did you bring copies of all reports? ☐ YES ☐ NO **(If yes, please give to medical assistant.)**

Are you happy with your current therapy and progress? ☐Yes ☐No
If **no**, please check concerns: ☐ lack of progress ☐ insufficient frequency ☐ additional treatment needed
☐ too many therapies ☐other (Please Explain)
_____
_____
_____

PLEASE COMPLETE BACK OF FORM

CHILDREN'S HOSPITAL
SUB-SPECIALISTS
OF CENTRAL TEXAS

A member of the
Seton Healthcare Network

Developmental Clinic

Patient Questionnaire
Follow-Up

Date: _____

What are your concerns about your child today?

_____

_____

_____

Does Your Child Have Any of These Symptoms? **(Mark NO if NO SYMPTOMS ARE PRESENT)**

General	☐ No	☐ Frequent Illness ☐ Poor Growth ☐ Recurrent Fever ☐ Decreased Energy
Eyes	☐ No	☐Vision Concerns ☐ Eye Crossing
ENT	☐ No	☐ Allergy Symptoms ☐ Ear Infections ☐Throat Infections ☐Hearing Concerns ☐ Abnormal Voice
Heart	☐No	☐Chest Pain ☐ Sweats w/Feeds ☐Blue Spells ☐Heart Murmur
Respiratory	☐No	☐ Cough ☐ Wheezing ☐Shortness of Breath
GI	☐No	☐ Wt loss ☐Wt gain ☐ Appetite loss ☐ Nausea ☐Vomiting ☐Constipation ☐Diarrhea ☐ Abdominal Pain ☐ Gagging/Choking ☐ Frequent Spitting ☐ Stool Accidents
GU	☐No	☐Urinary Tract Infections ☐ Hernias ☐ Frequent Urination ☐Daytime Urinary Accidents ☐Bedwetting
Skin	☐No	☐Birthmark ☐ Rash ☐Itching ☐Eczema
Neuro	☐No	☐Seizures ☐Headache ☐ Dizziness ☐Abnormal Movements ☐Staring
Heme	☐No	☐Bruises ☐ Nosebleeds ☐ Bleeding Gums
Sleep	☐No	☐Snoring ☐Trouble Falling Asleep ☐Night Wakings ☐Early Morning Wakings ☐Nightmares/Night Terrors ☐ Sleep Walking
Behavior	☐No	☐ Rocking ☐ Hand Flapping ☐ Head Banging ☐Toe Walking ☐Constant Movement ☐Puts objects in mouth

Please list all specialists seen, reason and last appointment:

Ophthalmology: _____ Orthopedics: _____
ENT: _____ Urology: _____
GI: _____ Neurosurgery: _____
Neurology: _____ Endocrinology: _____
Genetics: _____ Cardiology: _____
Pulmonology: _____ Craniofacial :_____
Surgery : _____ Other: _____

Reviewed with patient/family _____
Dr. Siv Fasci/Initial/Date

PLEASE COMPLETE BACK OF FORM