# Horn and Associates in Rehabilitation, PLLC

## Parent Questionnaire

Today's Date_____

**Identifying Information**

Child's Name_____ Date of Birth_____ Sex_____

Address_____ City_____ State_____ Zip Code_____

Home Phone_____ Cell Phone(s)_____ _____

Email Address(es)_____

Please * preferred method of communication above (home or cell phone, email)

1st Parent/Guardian Name_____Date of Birth_____SSN_____

Address (if different from above)_____

Occupation / Place of Work_____

2nd Parent/Guardian Name_____Date of Birth_____SSN_____

Address (if different from above)_____

Occupation / Place of Work _____

Billing Preference (please circle)

Insurance Private Pay Other_____

Responsible Party_____

Reason for referral / Concerns

_____

_____

Who referred child for services?_____

Physician Name_____

Physician Number and Address_____

2412 Greatstone Point
Lexington, Kentucky 40504

(859) 224-4081 (ph.)
(859) 224-4082 (fax)

4127 Todds Road
Lexington, Kentucky 40509

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Has the child received therapy services in the past?_____

If so, list type of service(s) and length of service(s)_____

Child's school and current grade / daycare_____

**Developmental and Medical History**

Was the child born full term? _____ If premature, how many weeks?_____

Please describe pregnancy (any infections or illnesses, stress, complications, medications, etc.)

_____

_____

Please describe labor and delivery (vaginal, Cesarean section, induction, complications, length of labor, etc.)

_____

_____

Please describe any significant neonatal issues (NICU stay, need for oxygen and/or fetal monitor, congenital abnormalities, need for surgery, difficulty with feeding, jaundice, colic, etc.)

_____

_____

Please list history of significant illnesses, surgeries, hospitalizations, etc., such as frequent ear infections, strep throat, gastrointestinal issues, seizures, asthma, allergies, need for ear tube placement, tonsillectomy, etc.

_____

_____

Please list any specialists your child has seen, along with when seen and reason for visit.

_____

_____

Has your child had a hearing evaluation? Please list findings_____

Has your child had a vision screening and/or wear glasses?_____

Please list any medications your child takes_____

Please list any diagnoses your child may have received

_____

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To the best of your knowledge, at what age did your child:

Roll over_____ Sit Independently_____ Crawl_____

Stand Alone_____ Walk_____ Go Up and Down Stairs_____

Finger Feed_____ Transition to Solid Foods_____ Transition from Bottle to Cup_____

Use Utensils to Feed Self_____ Toilet Train_____ Sleep through the Night_____

Say First Word_____ Put Two Words Together_____ Follow Simple Directions_____

**Family and Social History**

Please list individuals (with their ages and relationship to child) that live in the same home with the child

_____

_____

Do any family members or those living with child have a history of developmental concerns or delays? If so, please list relationship and concern

_____

_____

What is the primary language spoken in the home?_____

Are the any other languages spoken in the home? If so, please list_____

Does your child have interaction with same-age peers or other children?_____

Does your child interact well with other children?_____

What is your child's favorite activities/toys?_____

Please describe your child's personality and strengths_____

_____

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