Child's Name: ______________________________________ DOB: ____________
Parent: ____
School: ____
Date: ____

Initial Questionnaire

Parents, thank you for providing this information, it will assist us in determining the most appropriate evaluation tools and treatment modalities and is valuable when establishing therapy goals and monitoring progress.

Describe your pregnancy and birth with child. Gestational age? Hospitalization required after birth? Extended illnesses? Ear Infections?
Response:

Is your child on any medications now? Please list name, dosage, and time given.
Response:

TELL ME ABOUT YOUR CHILD.

- What kinds of things does your child enjoy?
- What things about your child do you especially enjoy?
- What are your child's gifts?

Response:

Home & Community – Are the parents married/divorced? Any siblings.

- When did parents become concerned about behaviors?
- Where does your child attend school/special programs?
- Physicians following your child.

Response:

PLEASE DESCRIBE THE MAJOR CONCERNS YOU HAVE AS TO WHY YOU ARE SEEKING OCCUPATIONAL THERAPY SERVICES FOR YOUR CHILD:

- What are you most concerned about now?

Response:

IN ORDER TO MEET YOUR NEEDS AND THE NEEDS OF YOUR CHILD IT IS HELPFUL FOR US TO BE AWARE OF ALL OTHER SERVICES YOUR CHILD IS RECEIVING AT THIS TIME (PLEASE LIST ALL SERVICES BEING RECEIVED EITHER AT SCHOOL OR PRIVATELY AND INCLUDE THE NAMES OF THE PROVIDERS)

Have you or are you receiving speech, physical, or occupational therapy services? If so, where, from whom and how long?

Have you or are you receiving psychology or family support services from the Child Development Center to support you and your child? If so, where, from whom and how long?

Functional Skills:

Gross Motor:

- Describe your child's gross motor skills (Can he walk, run, throw and catch a ball, ride a trike/bike with or without training wheels.
- Is your child involved in any sports/physical activities such as soccer, T-ball, baseball, swimming, horseback riding, creative movement, etc?

Response:

Fine Motor:

Tool Use (utensils, pencils):

- Describe how your child manages utensils such as a fork, spoon, and knife; pencil or crayon; scissors?
- Does your child hold utensils with a normal/standard tripod grasp?

Response:

Eating/Feeding

Does your family have a regular mealtimes? Sensitivities or preferences?

Dressing Skills:

- Does your child assist with dressing or dress independently?
- Does your child manage snaps, buttons, zippers and shoe tying independently or need assistance?
- How much time does it take for your child to get dressed?

Response:

Play Skills:

- Describe the play activities that your child engages in. Does your child play interactively with his peers? Does your child play independently?

Response:

Academics:

- Is your child attending a preschool or elementary school? What grade is your child in at school? Is your child in regular education? Resource room? Special education?
- Is you child successful at school? I s your child managing all aspects of his day at school or are there any areas of difficulty? Please describe.

Any teacher concerns: What, if any, concerns have the teacher(s) raised?

Response:

General State of Arousal:

- Is your child - Over responsive or under responsive to everyday stimuli? Do they seem overly sensitive to noise, light, touch? What strategies does you child use to help calm or to increase attention to task.

Response:

Temperament:

Need for Routine:

- Does your child do better with a structured routine?
- What happens if the routine is altered?

Response:

Sleep (settling, sleep, arising):

- Does your child have any difficulty getting to sleep in the evening? What strategies do you have to use to help your child go to sleep?
- Does your child sleep through the night?
- Does your child have any difficulty getting up in the morning?

Response:

Community Settings:

- Do any difficulties arise when your child is in stores, malls, restaurants, etc? Such as uncontrollable touching, sensitivity to noises, lights.
- Does he become over stimulated by the activity around him?
- What response does he have to over stimulation - does he shut down or become hyper?

Response:

Attention Span:

- Describe your child's attention span. Is it appropriate for his age?

Response:

Transitions:

- Does your child have difficulties with transitions?
- What strategies do you use if there are difficulties with transitions?

Response:

Activity level:

- Do you consider your child's activity level average for his age, not inactive, or overactive?

Response:

SOCIAL:

Family Members:

- How does your child interact with his/ her siblings and parents?

Response:

Peers:

- Does your child have friends in school and/or outside of school?
- Does your child make friends?
- Can your child maintain relationships and communicate with other children?
- Do friends tend to be older or younger?

Response:

In our effort to provide the most effective therapy services please list what are the areas of function that you would like to see change over the course of therapy for your child. For example change in the areas of tolerating sensory input relative to daily activities, dressing skills, gross and fine motor skills, play skills and social interaction.

Response:

Let's pretend that therapy is over and you are deciding whether treatment was successful. What are 5 or so changes that would make you say "Yes, that was worth the time, money and effort we put into it?"

Response: