Dymond Speech and Rehab.,P.A.

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Sanford, NC 27330

310 West Street
Pittsboro, NC 27312

Occupational Therapy Parent Questionnaire

Child's Name_____ Age: _____ Date of Birth:___/____/____ Sex: _____
Mother:_____ Age_____ Employment_____
Father:_____Age_____ Employment_____

Referral Information:
Who referred child for evaluation/therapy _____
What is your main concern regarding your child? _____
When were these concerns first noticed? _____
What does the doctor or others think caused this behavior? _____
What do you see as your child's strengths? _____

Birth History:
Describe any complications during pregnancy _____
Describe any complications during _____
Was the delivery at full term or premature_____ If premature, how early_____

Neonatal Period:
Birth weight_____ Apgar scores_____ Immediate cry after birth_____ Need assistance to breath_____ Why? _____
Any health problems during first 2 weeks of life_____
Did this require any hospitalization? If yes, how long? _____

Medical History:
Has your child ever been seen by any of the following (send copies of most recent results if available)
Neurologist (where, when, why) _____
Psychiatrist (where, when, why)_____
Psychologist (where, when, why)_____
List any specialist your child has seen and why (other than pediatrician or family doctor)_____
_____
Has your child ever had a _____CT scan _____MRI _____EEG Why? _____
Has your child had any of the following? (check if yes and put a X if still has):

____ADD/ADHD	____Congenital heart disease	____AIDS/HIV	____Chronic colds
____Asthma	____Autism	____Bronchitis	____Head injury
____Colic	____Ear infections	____Headaches	____Skin rash (Explain _____)
____High Fever	____LD	____Seizures	____Other_____

Has your child ever been hospitalized? _____ Why? _____
Has your child ever had surgery? _____ Why? _____
Are there any medical precautions of which the therapist should be aware when with your child? _____
_____

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Education History:

Current school_____ School district_____ Teacher_____
Grade_____ Is your child receiving resource assistance at school? Type? _____ How often_____
Is your child in a self-contained classroom? Type_____ Any mainstreaming? _____

Therapy History:

Is your child receiving or has received in the past (send copies if available):
Occupational Therapy (where, when, why)_____
Physical Therapy (where, when, why) _____
Speech Therapy (where, when, why) _____
Does your child use any specialized equipment? _____

Occupational Performance: (check all items that apply)

Activities of daily living

Dressing:

Does your child ___undress independently ___dress independently ___manipulate fasteners ___tie shoes
___select what to wear ___care for clothing (hang up, etc.)

Eating:

Does your child eat independently with ___spoon ___fork ___finger food ___spread with knife ___cut with knife
Drink out of ___cup ___straw
Does your child ___pour own drink ___get own snacks ___prepare own meal ___open container
Does your child have now or in the past any problems with ___sucking ___chewing ___choking
___difficulty switching to solid food ___limited food preferences for temperature of food ___dislike of certain food textures (what_____) ___dislikes/craving for strong flavors (what_____)
Favorite foods _____
Disliked foods _____

Toileting:

Is your child toilet trained ___day time (any accidents? ____) ___night time ___bowel trained
Is your child independent with ___toilet paper use ___managing clothing

Hygiene:

Does your child independently ___wash/dry hands ___bathe in tub ___shower ___shampoo
Does your child independently ___brush teeth ___manage toothpaste ___blow nose ___comb/brush hair

Functional communication:

Does your child speak in ___single words ___phrases ___sentences ___talk excessively
Does your child follow verbal directions ___1 step ___2 step ___3 or more steps
Does your child ___follow through on requests ___confuse directions of where sounds are coming
Is your child easily understood by others ___in the family ___outside the family
Does your child use language to communicate with other children ___

Sleep patterns:

Is/does your child ___have trouble falling asleep ___wake up frequently during night
___irritable when awakening ___ hard to get up ___ an immediate early riser ___fuss excessively when it is bedtime
Describe any "bedtime rituals" your child needs to go to bed _____

Is your child able/safe to move about the house independently (opening and shutting doors, going up and down stairs, Going outside, etc.) _____

Leisure/play:

Play/social interaction:

What is your child's favorite play activities _____

Does your child prefer to play with ___same age ___older kids ___younger kids ___adults

Does your child mostly play ___ alone ___beside others ___cooperatively with others

Make friends ___easily ___slowly ___rarely

Does your child ___need to always be in control ___usually follow another's lead

Does your child usually ___take turns ___share materials/toys ___apologize when needed ___use please and thank you ___break toys ___use eye contact ___push others ___bump into others ___react excessively to tickling ___know how to play with a new or unfamiliar toy

Does your child participate in conversations ___with family members ___with others

Playground/ recess/ sports

Does your child ___pump a swing ___ride a bike (training wheels? _____) or tricycle if younger ___jump rope ___throw /catch ball ___run ___skip ___kick ball ___use play ground equipment (slide, swing, etc.)

Is your child participating in organized sports or physical activities? If yes, what _____

Is your child _____ aware of safety concerns ___ a big risk taker ___ often bumping into objects

Outings:

Are any of the following difficult for you child? ___mall ___restaurant ___circus ___vacations ___birthday parties ___amusement parks ___other (what_____)

Does your child ___have good endurance for outings ___get easily overstimulated ___lack safety awareness on outgoings

Work/school/productive activities:

School:

Does your child transition easily to/from school? (ride bus, separate easily form parents, willing to enter school, etc.) _____

Does your child follow classroom rules? _____

Does you child easily tolerate changes in routine? _____

Is your child organized in the classroom? _____

Does your child ___follow directions ___complete work on time ___organize work on the paper ___work independently

Is your child able to ___tolerate noise in the cafeteria ___manage tray ___open drink container ___use fountain

Is your child able to ___move around school independently ___manipulate heavy doors ___use stairs

Does your child have a preferred hand ___right ___left ___both

Does your child have difficulty with ___assemblies ___field trips ___specials (art, music, etc.)

Does your child have ___letter reversals ___omit letters/words ___have trouble following with eyes

Home:

Does your child ___need frequent reminders to do homework ___organize materials and place for homework ___get up and down constantly while doing homework ___use strategies (music, TV, etc.) to do homework.

Does your child ___pick up toys ___put away clothes ___clean room ___set table ___take out trash ___help with grocery shopping ___make bed ___clean up spills ___other (what?_____)

Does your child ___easily tolerate changes in routines ___plan ahead ___make choices easily

Behavioral:

Is your child ___difficult to soothe/calm ___have strategies to self soothe

Is your child ___irritable ___prone to extreme /rapid mood shifts ___impulsive

Does your child ___pinch self ___bite self ___otherwise hurt self (how?_____)

OTHER INFORMATION

Has your child experienced any significant changes in the family such as severe illness, deaths, moves, divorce etc. _____

If so, how have this affected your child? _____

Any other information that might be helpful in understanding your child_____

_____

_____

CONTINUED ON BACK

List any hobbies and interests that your child enjoys. _____
_____
_____
_____
What are personal motivators for your child? _____
_____
_____
_____