

Dymond Speech and Rehab., P.A.
113 Hillcrest Drive 310 West Street
Sanford, NC 27330 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? _____

CONTINUED ON BACK

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 outings

Work/school/productive activities:

School:

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