



[www.atozpediatrictherapy.com](http://www.atozpediatrictherapy.com)

## OCCUPATIONAL THERAPY PARENT/CAREGIVER QUESTIONNAIRE

### **GENERAL INFORMATION**

Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Age: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Gender: \_\_\_\_\_

Parent 1 Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Parent 2 Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Parent 1 Occupation: \_\_\_\_\_

Level of Education: \_\_\_\_\_

Parent 2 Occupation: \_\_\_\_\_

Level of Education: \_\_\_\_\_

### **PATIENT HISTORY**

Who referred you for this evaluation? \_\_\_\_\_

Why did they refer you? \_\_\_\_\_

What are your main concerns? \_\_\_\_\_

What are your goals for therapy? \_\_\_\_\_

When was the problem first noticed? \_\_\_\_\_

Is your child aware of the problem?                      **Yes**                      **No**

If yes, how does your child feel about it? \_\_\_\_\_

How would you describe your child? \_\_\_\_\_

What are your child's strengths? \_\_\_\_\_

Does your child have any special interests? \_\_\_\_\_

Does your child use any type of adaptive equipment? \_\_\_\_\_

How have your child's habits/schedule changed in the past 6 months (meals, naps, school, bedtimes)? \_\_\_\_\_

**FAMILY INFORMATION**

List all people in household:

Name	Age	Sex	Grade	Relation

Is there family history of motor or sensory concerns? **Yes**      **No**

If yes, please describe: \_\_\_\_\_

What language(s) does your child speak? \_\_\_\_\_

What language(s) are spoken in the home? \_\_\_\_\_

Please describe below important cultural practices, rituals, traditions, or beliefs that you believe are important for us to be aware of prior to initiating a therapeutic relationship: \_\_\_\_\_

\_\_\_\_\_

Any other important information you would like to share with us: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**HEALTH & MEDICAL HISTORY**

Has your child ever been examined by any other professionals? **Yes**      **No**

Who	Date Seen	Findings/Results
Developmental Pediatrician		
ENT		
GI		
Neurologist		
Pediatrician		
Psychologist		
Psychiatrist		

Is your child currently on any medications? **Yes** **No**

Name	Dosage	Frequency	Purpose

How is your child's general health? \_\_\_\_\_

Please list any health conditions, surgeries, etc. of note: \_\_\_\_\_

Has your child had any ear trouble (earaches, infections)? **Yes** **No** #? \_\_\_\_\_

Has hearing been tested? **Yes** **No** Date: \_\_\_\_\_

Has your child ever had (PE) tubes inserted? **Yes** **No** Date: \_\_\_\_\_

Has your child ever worn glasses? **Yes** **No**

Has your child had any seizures? **Yes** **No**

Were there any noticeable changes in your child's general behavior, motor skills, or sensory development after certain life events, illnesses, surgeries, etc.? **Yes** **No**

If so, explain: \_\_\_\_\_

Does your child have any known **skin** allergies? **Yes** **No**

To Latex? **Yes** **No**

Does your child have any **food** allergies or is s/he on a restricted diet? **Yes** **No**

If so, please explain: \_\_\_\_\_

**BIRTH HISTORY**

Is the child adopted? Yes No At what age? \_\_\_\_\_

Does your child know s/he is adopted? Yes No

Complications or illnesses during pregnancy? **Yes** **No**

Medication taken during pregnancy? **Yes** **No**

If yes, please list: \_\_\_\_\_

Weight at birth \_\_\_\_\_

Was delivery? **Premature at \_\_\_ weeks** **Full-term** **Late at \_\_\_ weeks** **Induced**

Type of Birth: **Vaginal** **Caesarean** **Breech** **Forceps**

Did baby require: **Oxygen** **Tube Feed** **Transfusions** **NICU**

**DEVELOPMENTAL HISTORY AND INFORMATION:**

**MOTOR:**

Please indicate if motor milestones were met on time or delayed:

	<b>On Time</b>	<b>Delayed</b>
<i>Lift Head</i>		
<i>Roll over</i>		
<i>Sit Unsupported</i>		
<i>Stand alone</i>		
<i>Crawl on all fours</i>		
<i>Walk independently</i>		
<i>Bladder Trained</i>		
<i>Bowel trained</i>		

Does your child display hand dominance?

**Right**                      **Yes**                      **No**  
**Left**                        **Left**                      **No preference**

Can your child point using finger isolation?

**Yes**                      **No**

Does your child use a point independently?

**Yes**                      **No**

Does your child resist tooth brushing?

**Yes**                      **No**

Does your child have difficulty learning new motor skills:

**Yes**                      **No**

Can your child imitate motor skills?

**Yes**                      **No**

Please circle which one(s):

<i>Waving</i>	<i>Stomping Feet</i>	<i>Arms Up</i>
<i>Clapping</i>	<i>Roll Ball</i>	<i>Arms Out</i>
<i>Pointing</i>	<i>Peek-A-Boo</i>	<i>Thumbs Up</i>
<i>Head Nod</i>	<i>Head Shake</i>	<i>Jump</i>
<i>Open Mouth</i>		

Is your child clumsy or uncoordinated?

**Yes**                      **No**

Does your child have difficulties with handwriting?

**Yes**                      **No**

Does your child fatigue easily?

**Yes**                      **No**

Does s/he drool?

**Yes**                      **No**

**SENSORY PROCESSING:**

What are your child's sensory differences or needs? \_\_\_\_\_

\_\_\_\_\_

	Frequently	Sometimes	Never	Comments
<i>In constant motion or unable to sit still</i>				
<i>Trouble concentrating or can't stay on task</i>				
<i>Always runs, jumps, or stomps rather than walking</i>				
<i>Bumps into things or frequently knocks things over</i>				
<i>Reacts strongly to being touched/bumped</i>				
<i>Avoids messy play/ Doesn't like to get hands dirty</i>				
<i>Hates having hair washed, brushed, or cut</i>				
<i>Hates having fingernails cut</i>				
<i>Resists wearing new clothing or bothered by tags/socks</i>				
<i>Hesitates to play or climb on playground equipment</i>				
<i>Distressed by loud or sudden sounds</i>				
<i>Difficulties with balance</i>				
<i>Loses place when reading or copying from the board</i>				
<i>Difficulty tracking objects with eyes</i>				
<i>Mood variations, outbursts, and tantrums</i>				
<i>Difficulty calming down</i>				
<i>Avoids eye contact</i>				
<i>Trouble following multi-step instructions</i>				
<i>Picky eater</i>				
<i>Often gags on food</i>				
<i>Reacts strongly to smells</i>				
<i>High pain threshold</i>				
<i>Low pain threshold</i>				



Please rate your child's attention:

Preferred tasks	<b>Good</b>	<b>Fair</b>	<b>Poor</b>
Non-Preferred tasks	<b>Good</b>	<b>Fair</b>	<b>Poor</b>
Academic tasks	<b>Good</b>	<b>Fair</b>	<b>Poor</b>
During interactions with others	<b>Good</b>	<b>Fair</b>	<b>Poor</b>

**EDUCATIONAL HISTORY**

Name of current school: \_\_\_\_\_

Current grade: \_\_\_\_\_

Indicate performance level in school: **Above Average** **Average** **Below Average**

Previous Schools/Daycares: \_\_\_\_\_

Does your child receive: **Tutoring** **IEP** **504 plan**

If yes, please list services and frequency: \_\_\_\_\_

**THERAPY:**

Please provide information on therapies your child currently receives.

Therapy	How often?	Start Date?	Therapist Name	Location
Speech				
Occupational Therapy				
Physical Therapy				
Applied Behavior Analysis				
Floor Time				
Music				
Nutrition				
Other				

**BEHAVIOR/SOCIAL:**

Does your child play:      \_\_\_alone      \_\_\_with older kids      \_\_\_with peers      \_\_\_with younger kids

Does your child have close friends?      \_\_\_ Yes      \_\_\_ No

What are some of your child's favorite play activities? \_\_\_\_\_

Does your child have specific triggers for meltdowns? \_\_\_\_\_

What are your child's signs of enjoyment? \_\_\_\_\_

What are your child's overt signs of distress? \_\_\_\_\_

What are your child's most frequent problem behavior(s)? \_\_\_\_\_

Who primarily handles "discipline" or behavior-change procedures? \_\_\_\_\_

How are your child's problem behaviors typically addressed? \_\_\_\_\_

Does your child exhibit any repetitive behaviors? If yes, please describe: \_\_\_\_\_

Does your child exhibit any restricted routines (i.e., having to adhere to the same way of doing a common activity every time it is performed)? If yes, please describe: \_\_\_\_\_

What does your child do well? \_\_\_\_\_

What activities or objects are helpful in holding your child's attention? \_\_\_\_\_

What motivates your child? \_\_\_\_\_

What does your child have trouble doing? \_\_\_\_\_

**Is there anything else you would like us to know?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_