Pre-Evaluation Occupational Therapy Questionnaire Form

Child's Name____________________________ DOB______________

Describe your child's occupational therapy concerns: ____________________________________
____
____

How does your child usually communicate (e.g. gestures, sign language, single words, phrases, sentences, AAC)? ____

Has your child received occupational therapy services in the past? If so, where, when, and for how long? ____
____

Family History:

Siblings (names & ages): ____
____

Does your child live with both parents? If no, with whom does your child live?
____

If adopted, at what age? ____

Prenatal and Birthing History:

Describe mother's general health during pregnancy (illnesses, accidents, medication requirements, etc.) ____

Length of pregnanc: __________________________ Child's birth weight: ___________________

Describe deliver (any complications): ____
____

Describe your child's general health at birth: ____
____

Child's length of stay in hospital: ____

Child's current general health is: (circle one) Good Fair Poor

Please provide approximate ages at which your child has experienced any of the following illnesses/conditions:

Adenoidectomy ________	Headaches _____________	Pneumonia _____________
Asthma ________________	Head Injury _____________	Seizures _______________
Allergies _______________	Hearing Loss ____________	Sinusitis _______________
Chicken Pox ____________	Heart Problems ________	Sleep Difficulties ________
(Frequent) colds ________	High Fevers _____________	Thumb/Finger Sucking ________________________
Croup _________________	Influenza ______________	
Measles _______________	Epilepsy _______________	Tonsillectomy ___________
Vison Problems ________	Mumps ________________	Meningitis ______________
Ear Infections ___________	Ear Tubes ______________	Other _________________
How often? _____________	When? ________________	

Has your child experienced any major accidents, surgeries, illness, or hospitalizations? Please describe. ____
____

Please list any medications your child is currently taking: ___________________________________
____

Please list any medication allergies: ____
____
Are your child's immunizations up to date? ____
Is your child sensitive to latex? ____

Developmental History:

Please provide the approximate age at which your child began to do the following activities:

Activity	Age
Sit	
Crawl	
Stand	
Walk	
Feed self	
Dress self	
Use toilet	

Medical History:

Have any other doctors/specialists seen your child (audiologists, psychologists, occupational therapists, special educators, etc.?) If yes, please indicate the type of specialist, when the child was seen, and the specialist's conclusions or suggestions.

Name of Doctor/Specialist	Date(s) of Evaluation/Treatment	Please explain conclusions/treatment applicable

Any additional medical concerns/diagnoses relevant
____
____
____

Self-Care Development:

Please indicate if each skill is mastered, not mastered, in process of learning, or not applicable. Please add comments as necessary to indicate specific adaptations required for your child to complete a skill independently (e.g. visual schedule, initial assistance, verbal prompting, etc.).

Bathing/Toileting				
	Yes	No	In Process	Not applicable
Potty-trained				
Wets the bed				
Wipes well				
Pulls pants up/down				
Washes hands				
Showers/bathes				
NOTES:				
Feeding				
	Yes	No	In Process	Not Applicable
Finger feeds				
Uses spoon				
Uses fork				
Uses knife				
Picky eater				
NOTES:				
Play/Behavior				
	Yes	No	In Process	Not Applicable
Plays with others				
Temper tantrums				
Aggression/physical				
Self-harms				
Imitates				
Transitions				
Sleeps				
NOTES:				
Sensory				
	Yes	No	In Process	Not Applicable
Obsessions/compulsions				
Sensitive to sounds				
Sensitive to touch				
Seeks movement				

Seeks oral sensations (mouths toys, etc.)				
Seeks deep pressure				
NOTES:				

Dressing				
	Yes	No	In Process	Not Applicable
Puts on shirt				
Takes off shirt				
Puts on pants				
Takes off pants				
Puts on underwear				
Takes off underwear				
Puts on shoes				
Takes off shoes				
Ties shoes				
Zippers				
Buttons				
NOTES:				

Self-care/Hygiene				
	Yes	No	In Process	Not Applicable
Brushes teeth				
Brushes hair				
Applies deodorant				
Shaving				
NOTES:				

Socialization				
	Yes	No	In Process	Not Applicable
Eye contact				
Attention				
Responds to name/commands				
Follows multi-step directions				
Communication • Type: Verbal, gestures, sign, AAC, other				
NOTES:				

***For children ages 12 and older, please complete the following checklist.**

Emergency Situations				
	Yes	No	In Process	Not Applicable
Phone use/call 911				
Knows address & phone number				
Fire safety				
Weather events				
Emergency meeting location/plan				
Cooperates with authorities				
NOTES:				
Safety Awareness				
	Yes	No	In Process	Not Applicable
Stranger danger				
Danger to self/others				
Street/pedestrian safety				
Kitchen/household safety				
NOTES:				
Community Mobility				
	Yes	No	In Process	Not Applicable
Transportation Services				
Grocery/retail shopping				
Geographical awareness				
Internet/phone use				
NOTES:				
Household Management				
	Yes	No	In Process	Not Applicable
Meal preparation				
Laundry				
Cleaning				
Dishes				
Yard work				
NOTES:				

Fine and Gross Motor Development:

Has your child established hand dominance? If so, which hand? ___________________________

Does your child have difficulties with fine motor tasks (e.g. Lego's or building blocks, stringing beads, cutting, coloring/writing)? ____

____

Does your child have difficulties with walking, running, or participating in other activities that require large muscle movements and coordination? ____________________________________

____

School Services:

Does your child have a school-based Individualized Education Plan (IEP)? __________________

Does your child receive occupational therapy services at school? __________________________

If yes, what are the goal areas and how often? ____________________________________

____

Does your child receive speech or physical therapy services at school? _____________________

Miscellaneous:

Do you allow edibles (food/drink) as a means of reinforcing your child? __ Yes __ No

Dietary restrictions: ____