Name:_____
Preferred Name:_____
Preferred Pronouns: _____
Date of Birth:_____
Today's Date:_____

Please complete the following questionnaire to assist your OT/PT in developing the most appropriate rehabilitation program for your child. ***Thank you!***

Medical diagnosis and date:

_____

Please check all that apply:

❑Fractures/Sprains ❑Seizures/Epilepsy
❑Heart/lung Problems ❑Developmental Delay
❑Birth Complications ❑Cancer
❑Chronic Ear Infections ❑Repeated infection
❑Autism ❑Vision Problems
❑Tonsillectomy ❑Hearing Problems
❑Muscle Tone *Low High Varied*
❑Allergies _____
❑Surgeries_____
❑Other:_____

Your child's current medical team: (check all that apply)

❑ Primary care physician: _____
❑Orthopedist: _____
❑Neurologist: _____
❑ Physiatrist: _____
❑ Gastroenterologist: _____
❑ Cardiologist: _____
❑Pulmonologist: _____
❑Endocrinologist: _____
❑Developmental pediatrician: _____
❑Other: _____
_____

Is your child toilet trained? ❑Yes ❑No
Comments: _____

Does you child have any pain? ❑Yes ❑No
Location**:** _____
Pain Frequency: ❑ less than daily ❑ daily ❑constant
❑ night pain ❑ other _____

Is your child on any Medications? ❑Yes ❑No
If yes, list medications:_____

_____

Any family medical concerns? History of physical, emotional, speech, hearing, or learning problems in the family? Please describe: _____

_____

_____

Motivators, interests, sports, or hobbies: _____

_____

_____

Describe the problem(s) for which your child seeks therapy:

_____

_____

When did your current problem(s) begin? _____

Does your child have a PCA (Personal Care Attendant)? _____
Name: _____

Has your child received previous services?
❑ Yes (please check all that apply) ❑No

❑Occupational Therapy:
Initial Date: _____ Frequency: _____ Location_____
Name: _____
❑Physical Therapy:
Initial Date: _____ Frequency: _____ Location _____
Name: _____
❑Speech Therapy:
Initial Date: _____ Frequency: _____ Location_____
Name: _____
❑Hippotherapy:
Initial Date: _____ Frequency: _____ Location_____
Name: _____
❑Psychological treatment :
Initial Date: _____ Frequency: _____ Location_____
Name: _____
❑Other therapies: _____

School: _____
Does your child receive school services?
❑ Yes (please check all that apply) ❑No
Case manager: _____ contact: _____
❑Occupational Therapy:
Therapist:_____ contact: _____
❑Physical Therapy:
Therapist: _____ contact : _____

What other services does your child receive? (case management, ABA therapy, Howard services, 1 on 1 support, etc)

_____

Child lives with: (name and relation, please list all)

_____

_____

_____

Pregnancy and birth history:

Weeks gestation: _____

Any problems with mother/child health during pregnancy? _____

_____

_____

Any complications during delivery? _____

_____

Type of delivery: _____

Why? _____

Did the mother use any medications/substances during pregnancy? **(**including drugs/alcohol, cigarettes, antibiotics, sleeping pills, etc)

- ❑Yes : _____
- ❑ No
- ❑ Unsure

Did the child spend extra time at the hospital or in a special nursery?

- ❑Yes why? _____
- ❑ No

How did your child receive nutrition (ex. Breastfed, bottle fed, NG tube etc.)?

_____

Surgical History: (if applicable)

_____

_____

_____

_____

Can your child complete the following independently:

- ❑ tie a shoe
- ❑ put on socks
- ❑ button a shirt or pants
- ❑ snap pants
- ❑ zipper a coat
- ❑ brush teeth
- ❑ bathe or shower
- ❑ unscrew a lid
- ❑ climb the stairs
- ❑ ride a tricycle
- ❑ pump a swing

Hand dominance? ❑Left ❑Right ❑not decided

What age did your child complete the following:

	Age:
Roll over both ways	
Sit independently	
Crawl on hands and knees	
Cruise on furniture	
Walk	
Speak first word	
Drink from cup without lid	
Use a spoon	
Demonstrate hand preference	
Put on shirt	
Dress independently	

What are your child's strengths? _____

_____

What are your greatest concerns for your child relative to his/her development?

_____

_____

_____

Please comment on your child's behavior: _____

_____

_____