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Occupational Therapy Parent Questionnaire

What do you see as your child's needs, areas where you could use support?

_____

_____

_____

Please rate level of disruption current levels of difficulties interfere with daily life function:
1 = no interference 10 = constant interference

_____

What are your child's strengths?

_____

_____

_____

Please address your child's current ability in the following areas:

Attention(distracted easily/ limited):_____

_____

Transition between tasks(expected and unexpected):_____

_____

Dressing(independant/needs assistance/cues to stay on and complete task)

_____

_____

Fasteners: (buttons, snaps, zippers, tying shoes)_____

_____

Feeding: _____

_____

Toileting: _____

_____

Hygiene (bed wetting/bladder control/showering):_____

_____

Sleep: _____

_____

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When surprised or scared does your child freeze or run?_____

How easily are they comforted?_____

_____

Please summarize your goals for your child. What would you like to accomplish in therapy?

_____

_____

_____

Fine motor goals (if applicable)

_____

_____

_____

Gross motor goals (if applicable)

_____

_____

_____

Social goals, self-care goals (if applicable)

_____

_____

_____

_____

_____

Other goals

_____

_____

Parent/Guardian's Signature _____Date _____

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Medical/Developmental History

Full term Pregnancy? Y N Normal Birth Process? Y N

Any complications before, during or immediately following delivery? Y N

_____

_____

Did you child crawl (stomach off floor) Y N at what age_____

What age did your child walk? _____ Was your child active? Y N

Speech: First words at _____ Was early speech clear to others? Y N

Is speech clear now? Y N

Is your child generally healthy?

Any problems with ear infections?____ High fever ____ Asthma ____ Allergies _____

Any illnesses, bad falls, etc. and at what age did they

occur?_____

_____

Is your child on any medication? Please list ALL and reason for taking.

_____

_____

_____

_____

Any current/previous diagnosis:_____

Has your child received specialized services before? (circle)

Occupational Therapy Speech Therapy Physical Therapy Tutoring/Special Ed

Are these ongoing? Y N

If so please describe support given_____

_____

_____

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Academics

Attends which school and grade?_____

Reading Level:_____ Does your child like to read? Y N Voluntarily? Y N

Please explain:_____

How do you feel your child is doing in school? ___ Well ____ Below potential ____Poor

What subjects are easy for your child?_____

What subjects are difficult?_____

Family and Home

Please indicate whom he/she lives with: (circle) Mother Father Step-Mother Step-Father other adults_____

Siblings and ages_____

Has he/she ever been through a traumatic family situation (divorce, illness, death)?

_____

_____

At what age and have they adjusted?_____

Is family life stable at this time?_____

Thank you for providing the above information.

Parent/Guardian's Signature _____

Date _____

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