106 East 25th Ave.
Covington, LA 70433
985-327-5352

Individualized Needs Assessment (OT)

Child's name: ____ Date of Birth: ______________

Name of person completing this form: ____

Relationship to child: ____

Is your child adopted? Yes No

Birth History

Did the mother have any complications during pregnancy? Yes No

If yes, please describe____

Child was born: full-term______ premature ______ If premature, how many weeks? _________

Delivery: vaginal ______ with forceps ______ C-section ______

Were there any complications? ____

Was your child placed in the Newborn Intensive Care Unit? ______ If so, how long? ___________

Please describe any other medical problems or complications at birth.

____

Developmental History

Please indicate at what age your child achieved the following milestones. Mark N/A for those which your child has not achieved yet.

Rolled over ____________________Sat alone ____________________

Crawled ____________________Pulled to stand ____________________

Stood independently ____________________ Walked independently ____________________

Babbled____________________Said first word ____________________

Drank from a cup ____________________Used spoon____________________

Toilet trained ____________________

Dressed self ____________________

Any current physical limitations: Yes No

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If yes, please describe____

Comments: ____

____

Medical History

Current diagnosis: ____

Current physician(s). Please list all that child sees currently.______________________________

____

____

Any previous hospitalizations: Yes No

If yes, please list____

Any previous Surgeries: Yes No

If yes, please list ____

Previous psychological evaluation: Yes No

If yes, please describe or provide copy of evaluation.__________________________________

____

____

Medications: Yes No

If yes, please list dosage and frequency ____

____

Allergies: Yes No

If yes, please list and list reactions ____

____

Does your child use any special equipment? Yes No

If yes, please describe ____

Any feeding concerns? Yes No

If yes, please describe____

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Does your child have a history of ear infections? Yes No

Does your child have or had tubes placed in his/her ears? Yes No

If yes, when?____

Any vision concerns? Yes No

If yes, please describe____

Caregiver Concerns

What are your main concerns with your child? ___________________________________

____

What are your child's strengths? ____

____

Has your child received occupational therapy, physical therapy, or speech therapy in the past or currently receives services? Yes No

If yes, please indicate where, which services, and for how long:__________________________

____

____

____

Educational Information

School/Educational program currently attending:

____

Current grade level: ___________________

Does your child have an IEP? Yes No

Please circle if your child receives any of the following:

OT PT Speech Special Education Behavior Intervention

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If yes, please list frequency and duration of these services:________________________________

____

Other special service not listed____

Please circle if your child's teacher have concerns with your child's development in any of the following areas:

Motor skills Social abilities Self-help skills Learning abilities

Comments: ____

____

Social/Emotional Development

Please describe your child's personality____

____

Does your child interact well with others? Yes No

Does your child have any trouble making friends? Yes No

Does your child have difficulty calming himself/herself when upset? Yes No

Comments____

____

Thank you for taking the time to fill out this questionnaire. This information will help us to become more familiar with your child and allows us to provide the best service possible to you and your child.

Signature: ____Date: _____________

Patient Name ____