Date of Consult: ________________ **Schedule Evaluation** ( ) Yes ( ) No **Schedule Consult Follow-up** ( ) Yes ( ) No

Occupational Therapy Consultation

Child's Name: ____ DOB: _________________________

Parent's Name: ____ Phone #: ______________________

Address: ____

E-Mail: ____

1. Why are you seeking an occupational therapy consultation?

2. What is your primary concern with your child?

3. What is the most difficult part of the day for your child?

4. Is your concern related to your child's self-care skills, such as dressing, sleeping, eating, or bathing?

5. Is your concern related to your child’s emotions and behavior, such as excessive tantrums or difficulty managing big emotions?

6. Is there a time of day is particularly difficult? Or a particular task?

7. Does you child have any diagnosis? (ADHD, Autism, ect.)

8. Have they had any other services, such as Early On, counseling, Speech, PT? If so, can you bring that eval or any forms necessary. *If not, what have you tried at home?*

9. If you could ask the consulting therapist *one question* regarding your child, what would it be?