Advanced Therapy Care

Therapy Services for Adults and Children

New Patient Occupational Therapy Questionnaire

PATIENT INFORMATION			
Patient's Last Name:	**First:**	**Initial:**	**Birthdate:**
Current School:		**Grade:**	**Services at School?** ☐ Yes ☐ No If yes, please sign release and bring copy of current IEP

Why are you having your child evaluated by Occupational Therapy?

Brief medical history:

Does your child currently take any medications? If yes, please list

Does your child have a history of the following? If yes, please explain

Developmental Delay / Disability	☐ Yes ☐ No	
Traumatic Brain Injury	☐ Yes ☐ No	
Cardiopulmonary Dysfunction	☐ Yes ☐ No	
Hematologic D/O	☐ Yes ☐ No	
Musculoskeletal D/O	☐ Yes ☐ No	
Neuromuscular D/O	☐ Yes ☐ No	
Burn Injuries	☐ Yes ☐ No	
Infectious Conditions	☐ Yes ☐ No	
Cancer	☐ Yes ☐ No	
Diabetes	☐ Yes ☐ No	
Birth Defects	☐ Yes ☐ No	
Aggression:	☐ Yes ☐ No	**(hitting, biting, kicking, punching, throwing objects)**

Other: ☐ Yes ☐ No _____

Are you concerned about the way your child uses his/her body to play, do school work, or do every day tasks?
☐ Yes ☐ No

Please describe your concerns:

_____

_____

_____

Are there upper body (posture, shoulder, arm, head, and/or fingers) concerns?

_____

_____

When and why did you become concerned about your child's movement abilities?

_____

_____

_____

Do you have concerns related to eye/hand coordination? (reading the board and copying) ☐ Yes ☐ No

If yes, please describe:

_____

_____

_____

Can your child follow directions? ☐ Yes ☐ No

Does your child play with peers? ☐ Yes ☐ No

Does your child play on the playground? ☐ Yes ☐ No

Does your child play with toys? ☐ Yes ☐ No

Are you concerned about the way your child perceives the following sensory information?

☐ Auditory/Hearing ☐ Mouth/Oral

☐ Visual ☐ Touch/Tactile

☐ Balance

My child walked at: _____

My child crawled at: _____

Is your child over-reactive, reactive/sensitive, or under-reactive to the above? (please describe)

Does your child have difficulty with social or emotional responses? (please describe behaviors)

What are your child's strengths and weaknesses?

Is there anything you'd like to report about your child's functioning?

Do you have any additional concerns not previously reported?

Are you concerned about your child's communication skills? ☐ Yes ☐ No

Please describe your concerns: