talk&play ASSOCIATES

New Patient Occupational Therapy Questionnaire

PATIENT INFORMATION			
Patient's Last Name:	First:	Middle 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 any of the following? (f yes, please describe.

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 _____

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? (e.g. reading the board and copying) ☐ Yes ☐ No

If yes, please describe:

_____

_____

_____

Can your child follow directions? ☐ Yes ☐ No

Does you 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 My child walked at: _____

☐ Visual ☐ Touch/Tactile My child crawled at: _____

☐ Balance

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?

_____

_____

_____