

**PARENT QUESTIONNAIRE  
OCCUPATIONAL THERAPY SERVICES**



**Please return as soon as possible.**

The information you give us will help us to understand your child and to better plan for his or her visit. Not all questions may apply to your child. **Please print a copy, complete and fax or mail as soon as possible to your clinic. If you do not send ahead of time, please bring completed form with you to the evaluation.**

Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: Male  Female

Medical or Developmental Diagnosis: \_\_\_\_\_

Language(s) Spoken at Home if other than English: \_\_\_\_\_

Parent(s) or Guardian(s) name(s): \_\_\_\_\_

With whom does the child live? \_\_\_\_\_

Person completing questionnaire: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Phone numbers please list best contact numbers: \_\_\_\_\_

Email Address: \_\_\_\_\_

Brothers/Sisters (Include names and ages): \_\_\_\_\_

**REASON FOR REFERRAL**

Who referred you for this evaluation? \_\_\_\_\_

Why did they refer your child for this evaluation? \_\_\_\_\_

What are your main concerns about your child? \_\_\_\_\_

What are your goals for therapy? \_\_\_\_\_

What are your child's strengths? \_\_\_\_\_

**MEDICAL HISTORY**

Were there any problems during your pregnancy? Yes  No

Were there any problems during your child's birth? Yes  No

Has your child had any significant illnesses, injuries, and/or hospitalizations? Yes  No

If yes to any of the above, please describe: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List any medications currently taken by your child: \_\_\_\_\_

\_\_\_\_\_

Does your child have any allergies? Yes  No

If yes, please list: \_\_\_\_\_

Is your child on a specific diet or food restrictions? Yes  No

If yes, please list: \_\_\_\_\_

Does your child have regular sleeping habits or good ability to fall asleep and stay asleep? Yes  No

If no, please describe: \_\_\_\_\_

\_\_\_\_\_

Does your child have a history of frequent ear infections? Yes  No  Age Started: \_\_\_\_\_

If yes, how many infections did he/she have in the past year? \_\_\_\_\_

Does your child have ear (PE) tubes? Yes  No

Has your child's hearing been tested? Yes  No

If yes, when/where: \_\_\_\_\_ Results: \_\_\_\_\_

Has your child's vision been checked? Yes  No

If yes, when/where: \_\_\_\_\_ Results: \_\_\_\_\_

**EDUCATIONAL INFORMATION**

Does your child receive early intervention services through the school district? Yes  No

Does your child currently attend school? Yes  No

Name of School/Grade: \_\_\_\_\_

Does your child have a current Individual Education Plan (IEP) or Individual Family Service Plan (IFSP)?

Yes  No

Daycare or other programs: \_\_\_\_\_

## OTHER PROFESSIONALS

Please check if your child is currently receiving any of the following services or have in the past, and provide location:

- Occupational Therapy  \_\_\_\_\_
- Physical Therapy  \_\_\_\_\_
- Speech Therapy  \_\_\_\_\_
- Psychology  \_\_\_\_\_
- Neurology  \_\_\_\_\_
- Gastroenterology  \_\_\_\_\_
- Other  \_\_\_\_\_

**\*\*Please bring copies of any formal evaluations/screenings you feel would be helpful at your appointment.**

## DEVELOPMENT, SELF CARE & DAILY ROUTINES

Please list approximate ages that your child accomplished major developmental milestones:

Rolling: \_\_\_\_\_ Sitting: \_\_\_\_\_ Crawling: \_\_\_\_\_

Walking: \_\_\_\_\_ Talking: \_\_\_\_\_

Does your child communicate verbally? Yes  No

If your child is non-verbal, describe how do they communicate with you? \_\_\_\_\_

### **Please indicate if you have concerns in any of the following areas:**

Check level of performance your child is able to complete:

#### **Dressing Skills:**

Child can independently dress self? Yes  No

Child can zip and button clothing? Yes  No

Child needs occasional assistance to dress? Yes  No

Child is starting to push arms through sleeves; legs through pant legs? Yes  No

Parent dresses child on a daily basis? Yes  No

Comments: \_\_\_\_\_

#### **Feeding Skills:**

Do you have concerns about your child's eating habits? Yes  No

Child is a very picky eater will only eat certain foods or textures? Yes  No

Feeding utensils:

- Child uses spoons/forks at every meal? Yes  No
- Occasionally or needs reminders to use utensils? Yes  No
- Never uses utensils. Yes  No

Child eats an adequate amount of food for his/her age? Yes  No

Child is willing to sit at table/highchair for all meals. Yes  No

Comments: \_\_\_\_\_

**Motor Skills:**

- Child appears clumsy or uncoordinated? Yes  No
- Child has difficulties with handwriting? Yes  No
- Child fatigues easily and has poor endurance? Yes  No
- Child has difficulties learning new motor skills? Yes  No

Comments: \_\_\_\_\_

**Social Interactions:**

- Does your child play with age appropriate toys? Yes  No
- Does your child respond when his/her name is called? Yes  No
- Does your child have difficulties with transitions to new activities/environments? Yes  No
- Does your child have difficulties with changes in routine? Yes  No
- Does your child have poor frustration tolerance? Yes  No
- Does your child have poor safety awareness in the community? Yes  No
- If your child is upset or angry do they have difficulties calming and coping with anger? Yes  No

Comments: \_\_\_\_\_

Do you have concerns about your child's ability to play with other children? Yes  No

Please describe: \_\_\_\_\_

**Sensory Processing:**

Does your child have significant fear, aversion or difficulties with the following items?

- Washing/cutting hair Yes  No
- Cutting finger nails Yes  No
- Brushing teeth/oral care Yes  No
- Loud and unexpected sounds Yes  No
- Clothing textures/fabric Yes  No
- Avoids swings/climbing/movement Yes  No
- Avoids messy play/getting dirty Yes  No

Do any of the following statements describe your child?

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| Difficulties with calming down         | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Difficulties focusing attention        | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Engages in risky play activities       | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Prefers rough play                     | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Child craves movement                  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Child is constantly moving "on the go" | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Any other comments or questions you have for the therapist: \_\_\_\_\_

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**Please return this questionnaire before your appointment** to help us plan a thorough evaluation. It may be returned in person, by mail, or by fax to:

**Maple Grove**, 7767 Elm Creek Boulevard, Suite 300, Maple Grove, Minnesota 55369  
Phone: (763) 416-8700    **Fax: (763) 416-8701**

**Minneapolis**, 2530 Chicago Avenue South, Minneapolis, Minnesota 55404  
Phone: (612) 813-6709    **Fax: (612) 813-6593**

**Minnetonka**, 5950 Clearwater Drive, Suite 500, Minnetonka, Minnesota 55343  
Phone: (952) 930-8630    **Fax: (952) 930-8640**

**Roseville**, 1835 West County Road C, Suite 130, Roseville, Minnesota 55113  
Phone: (651) 638-1670    **Fax: (651) 638-1675**

**St. Paul**, 345 North Smith Avenue, St. Paul, Minnesota 55102  
Phone: (651) 220-6880    **Fax: (651) 220-7299**

**Woodwinds**, 1825 Woodwinds Drive, Suite 100, Woodbury, Minnesota 55125  
Phone: (651) 232-6860    **Fax: (651) 232-6766**