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?

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Brief medical history:

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

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

Condition	Yes	No	Explanation
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:

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

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

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

If yes, please describe:

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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: