South Sound Pediatric
Occupational Therapy
Empowering Parents and Professionals

PATIENT QUESTIONNAIRE

Thanks for choosing South Sound Pediatric OT. This questionnaire provides important information to help tailor your child's evaluation and treatment to their individual needs. Please fill it out and return by mail, fax, e-mail.

General Information:

Child's Name: Birthdate:

Parent(s) or Guardians(s) Names and relationship to child:

Address:

Phone numbers:

E-mails:

Household members: (Parents, Siblings (ages), people living in home with family):

Is English your first language?
If not, what is your first language?

***Physician Information**:*
Child's Physician:
Physician's Phone:
Referred By:

Concerns:

What are your concerns regarding your child? (Why are you seeking OT services?)

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What do you want your child to be doing that he/she is not doing?

What strategies have you tried to help your child regarding the above challenges?

Who suggested that your child see an occupational therapist?

Has your child been evaluated or treated by other therapists? occupational, physical, speech? If so, when, for what concerns, and through what company/agency?

Is your child receiving any therapy or other intervention services at this time? If so, what service(s), what areas are being addressed, how often is your child being seen and through what company/agency?

Does your child have a diagnosis related to his/her above developmental challenges?

How would you describe your child's temperament?

What are your child's strengths? What is he/she good at doing?

What are your child's favorite activities and toys? Favorite characters or television shows?

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How much time does your child spend watching tv or using technology per day (if applicable)?

How much time does your child spend outside playing? And what are the preferred activities?

Medical History:

Was your pregnancy typical or were there complications? If there were complications, please explain.

Was your child born full term or premature? If so, how many weeks?

Was he/she born vaginally or by cesarean section?

Did he/she have any medical issues at birth? If so what were they?

How much did your child weigh?

How long did the two of you stay in the hospital after the birth?

Has your child had any significant or recurrent medical issues? If so please explain.

Has your child been hospitalized, had surgery, or any major illnesses? If so please explain.

Do you have concerns regarding your child's vision?
Does your child wear corrective lenses?
If so, for what condition?

Physician/Optometrist:

Do you have concerns regarding your child's hearing?

Has your child received a hearing screening or evaluation? If so, when and where?

Results of evaluation, if applicable:

Is your child currently taking any medications or a history of medication use? Please include homeopathic remedies, over-the-counter medications, and vitamins, if applicable:

Does your child have allergies and what is the treatment for those allergies? (ie. peanuts, latex?)

Note: If your child has life-threatening allergies which require an epi-pen, please ensure an epi-pen is available at all times during therapy.

Developmental History:

At what age did your child: Smile at you? Rollover? Sit up?

Walk by himself/herself? Say his/her first word?

When did you first have concerns regarding your child's development and what were the concerns?

***School History**:*
Is your child currently enrolled in a school program?
Where:
Grade:
Does your child currently have an IEP within the school district? If yes, what services are provided:

Did your child attend a birth to three program? If yes, what services were provided on the IFSP:

What subjects in school does your child do well?

What subjects does your child have difficulty with?

Has your child's teacher mentioned concerns regarding academics, attention or behavior?

Are there other family members with learning challenges? If yes, please describe:

Life at Home:

What strategies do you use at home for supporting positive behavior?

When your child is upset, what is the best strategy for calming?

Activities of Daily Living:

Does your child have any sleeping issues? (i.e. difficulties falling asleep or staying asleep?)

Does your child have a regular bedtime routine? Please explain:

Do you have any concerns regarding your child's feeding/eating? If so, please describe:

Is your child toilet trained?

If not does she/he wear diapers or pull ups?

Is your child able to do any of the following **independently**?		Please circle:
Dress/Undress self	Yes	No
Dons/Doff coat/jacket	Yes	No

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Manage zippers, snaps, buttons	Yes	No
Feeds self finger foods	Yes	No
Use utensils for eating	Yes	No
Drinks from open cup	Yes	No
Bathes self	Yes	No
Brush teeth	Yes	No
Take off/Put on shoes	Yes	No
Tie shoelaces	Yes	No
Help with simple chores (ie. put away toys)	Yes	No

Additional Comments:

Thank you for taking the time to complete this form thoughtfully! Please return by mail, e-mail, or fax.

Dawn Heino, OTR/L

Pediatric Occupational Therapist

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