1935 County Road B2, Suite 100
Roseville, MN 55113

Occupational therapy Questionnaire

Child's Name:	Parent Name:
Age:	Parent Name:
Date of Birth:	School (if applicable)
Sex:	Grade level (if applicable):

Referral Information

Who referred your child for an evaluation/therapy:
What is your main concern regarding your child?
When were these concerns first noticed?

Birth History

Describe any complications during pregnancy: ____

Describe any complications during delivery: ____

Was the delivery at full term or premature? ____

If premature, how early? __________________________________

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Medical History

Has your child ever been seen by any of the following:

Neurologist (Where, When, Why): ____

Has your child ever been hospitalized? _________

Why? ____

Has your child ever had surgery? ___________

Why? ____

Are there any medical precautions of which the therapist should be aware of when with your child?

____

Therapy History

Is your child receiving or has received in the past (send copies if available): Occupational Therapy (where, when, why): ____

Physical Therapy (where, when, why): ____

Speech Therapy (where, when, why): ____

Occupational Performance: (check all items that apply) Activities of daily living

Dressing:

Does your child:

___ undress independently

___ dress independently

___ manipulate fasteners

___ tie shoes

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Eating:

Does your child eat independently with:

___ spoon ___ finger food ___ cut with knife

___ fork ___ spread with knife

Drink out of:

___cup ___straw

Does your child:

___ pour own drink ___ prepare own meal

___ get own snacks ___ open container.

Does your child have now or in the past any problems with:

___ chewing ___ choking

___ difficulty switching to solid food ___ limited food preferences for temperature of food

___ dislike of certain food textures (what: ________________)

___ dislikes/craving for strong flavors (what________________________________)

Toileting:

Is your child toilet trained _______

Day time (any accidents?) _______ Night time: _________ Bowel trained: _________

Is your child independent with:

toilet paper use: _________ managing clothing:_______

Hygiene:

Does your child independently:

_____ wash/dry hands _____ comb/brush hair

_____ brush teeth

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Work/school/productive activities:

School:

Does your child currently receive any accommodations in school?

____

Does your child currently have an IEP or a 504-plan? If so, what does it include?

____

Does your child transition easily to/from school? (ride bus, separate easily form parents, willing to enter school, etc.)

____

Does your child follow classroom rules?

____

Does your child easily tolerate changes in routine?

____

Is your child organized in the classroom?

____

OTHER INFORMATION

Any other information that might be helpful in understanding your child

____

____

List any hobbies and interests that your child enjoys.

____

____

What are personal motivators for your child?

____

____