Date:_____

INITIAL QUESTIONNAIRE

Child's Name:_____ Nickname: _____

Date of Birth:_____/_____/_____ Age: _____ years, _____ months

Parent Name(s): _____

Address: _____

City/State/Zip: _____

Phone # (Home/Cell/work):_____

_____

Email: _____

Name of person completing form: _____

Relationship to child: _____

Names and ages of siblings: _____

_____

Other family members in the household: _____

_____

Referred by (Name/Address/Profession):_____

_____

MEDICAL HISTORY

Medical Diagnosis: _____

Current Medications (include start date and reason for medication): _____

_____

_____

Has your child's vision been tested? ☐ Yes ☐ No If yes, when? _____

Has your child's hearing been tested? ☐ Yes ☐ No If yes, when? _____

What were the results of hearing and vision tests? _____

_____

Has your child experienced any of the following (describe and provide approximate dates):

1) Childhood diseases or major illnesses? _____

2) Congenital Abnormalities? _____

3) Surgery/Serious Injury? _____

4) Seizures? _____

5) Allergies? _____

6) Ear Infections? _____

7) Ear Tubes? _____

8) Trauma/abuse? _____

Has your child taken antibiotics? _____ If yes, how many rounds? _____

Does your child use and assistive devices (e.g. glasses, orthotics, wheelchair, etc.)? _____

_____

Does your child have any medical precautions that the therapist should be aware of? _____

_____

Has your child received other evaluations or treatments (e.g. psychological, speech and language, occupational therapy, physical therapy, neurological, etc.)? ☐ Yes ☐ No

If yes, please describe:

Type	Evaluation Date	Professionals Name	Dates of Therapy

Mother's Health during Pregnancy

Did the child's mother experience any of the following during pregnancy:

1) Infections/Illnesses? ☐ Yes ☐ No If yes, describe: _____

_____

2) Shock/Unusual stress? ☐ Yes ☐ No If yes, describe: _____

_____

3) Medications? ☐ Yes ☐ No If yes, describe: _____

_____

4) Complications? ☐ Yes ☐ No If yes, describe: _____

_____

5) Difficult labor/delivery? ☐ Yes ☐ No If yes, describe: _____

_____

Child's Birth

Was your child:

1) Born early or late? ☐ Yes ☐ No

If yes, describe (# weeks, weight): _____

2) In the NICU ☐ Yes ☐ No

If yes, describe (# weeks): _____

3) Adopted? ☐ Yes ☐ No

4) Distressed/Injured at birth? ☐ Yes ☐ No

If yes, describe: _____

5) Delivered by forceps or suction? ☐ Yes ☐ No

If yes, describe: _____

6) Delivered by cesarean section? ☐ Yes ☐ No

DEVELOPMENTAL HISTORY

Infancy and Early Childhood

Does or did your child:

1) Have difficulty with feeding? ☐ Yes ☐ No

If yes, describe: _____

2) Have difficulty with sleeping? ☐ Yes ☐ No

If yes, describe: _____

3) Cry frequently? ☐ Yes ☐ No

If yes, describe: _____

4) Seem difficult to soothe or calm? ☐ Yes ☐ No

If yes, describe: _____

5) Have colic? ☐ Yes ☐ No

If yes, describe: _____

6) Prefer certain positions? ☐ Yes ☐ No

If yes, describe: _____

7) Prefer certain movements (e.g. bouncing)? ☐ Yes ☐ No

If yes, describe: _____

8) Go through the "terrible twos"? ☐ Yes ☐ No

If no, describe toddler phase: _____

When did your child (describe age in months and anything unusual about milestones):

1) Roll over? _____

2) Sit alone? _____

3) Crawl? _____

4) Say first words? _____

5) Chew solid food? _____

6) Drink from a cup? _____

7) Walk? _____

8) Use a spoon? _____

9) Use crayons? _____

10) Say 2-3 word phrases? _____

11) Use the toilet? _____

CURRENT LEVELS OF PERFORMANCE

Speech and Language

How does your child currently communicate (e.g. words, sounds, gestures, etc.)? _____

_____

How many words can your child say? ☐1-10 ☐10-50 ☐50-100 ☐100-300 ☐300-500

Does your child understand or speak other languages? ☐ Yes ☐ No

If yes, describe: _____

Self-care

Does your child have difficulty with:

1) Putting on/taking off clothing? ☐ Yes ☐ No

If yes, describe: _____

2) Managing fasteners? ☐ Yes ☐ No

If yes circle all that apply: snaps buttons zippers buckles tying

3) Bathing (tilting head back)? ☐ Yes ☐ No

If yes, describe: _____

4) Brushing teeth? ☐ Yes ☐ No

If yes, describe: _____

5) Brushing hair? ☐ Yes ☐ No

If yes, describe: _____

6) Sleeping (falling/staying asleep)? ☐ Yes ☐ No

If yes, describe: _____

7) Bed-wetting? ☐ Yes ☐ No

If yes, how often? _____

8) Opening containers? ☐ Yes ☐ No

If yes, describe: _____

9) Self-feeding? ☐ Yes ☐ No

If yes, describe: _____

6) Eating a variety of foods? ☐ Yes ☐ No

If yes, describe: _____

School Skills

Name of school/day-care: _____ Grade: _____

Days per week: _____ Teacher(s): _____

Does your child have an IEP? ☐ Yes ☐ No

What accommodations does your child use in school (e.g. additional time, small class sizes, visual schedules, etc.)? _____

_____

Does your child have difficulty with:

1) Using arts and craft supplies? ☐ Yes ☐ No

If yes, describe: _____

2) Writing? ☐ Yes ☐ No

If yes, describe: _____

3) Reading? ☐ Yes ☐ No

If yes, describe: _____

4) Sitting still? ☐ Yes ☐ No

If yes, describe: _____

5) Attending in large groups? ☐ Yes ☐ No

If yes, describe: _____

Play Skills

What are your child's favorite activities, games, or toys? _____

_____

_____

Does your child typically play alone or with others? _____

_____

Does your child have any difficulty with:

1) Learning new movements? ☐ Yes ☐ No

If yes, describe: _____

2) Listening to music? ☐ Yes ☐ No

If yes, describe: _____

3) Singing? ☐ Yes ☐ No

If yes, describe: _____

4) Attending to preferred activities? ☐ Yes ☐ No

If yes, describe: _____

5) Playing with other children? ☐ Yes ☐ No

If yes, describe: _____

How many hours per day does your child spend doing the following activities:

1) Physical or movement activities? _____

2) Playing video games? _____

3) Watching TV? _____

4) Playing on the computer? _____

5) Using other devices (phones, tablets, etc.)? _____

Sensory Preferences

Does your child prefer or avoid:

1) Specific sounds/noises? ☐ Yes ☐ No

If yes, describe: _____

2) Sights or visual inputs? ☐ Yes ☐ No

If yes, describe: _____

3) Movements? ☐ Yes ☐ No

If yes, describe: _____

4) Head/body positions? ☐ Yes ☐ No

If yes, describe: _____

5) Smells? ☐ Yes ☐ No

If yes, describe: _____

6) Textures? ☐ Yes ☐ No

If yes, describe: _____

7) Touching others/objects? ☐ Yes ☐ No

If yes, describe: _____

8) To use more/less body force? ☐ Yes ☐ No

If yes, describe: _____

Behaviors

Does your child have difficulty with:

1) Transitioning to another activity? ☐ Yes ☐ No

If yes, describe: _____

2) Attending to activities? ☐ Yes ☐ No

If yes, describe: _____

2) Adjusting to changes? ☐ Yes ☐ No

If yes, describe: _____

3) Temper tantrums? ☐ Yes ☐ No

If yes, describe:_____

4) Complying with routine activities? ☐ Yes ☐ No

If yes, describe: _____

Emotional Health

Does your child frequently experience (circle all that apply)?

Excessive shyness	Self-doubt
Difficulty separating from parents	Worthlessness
Sadness	Irritability
Strong fears/Anxiety	Extreme ups and downs
Anger	Depression
Aggression	Hopelessness

What makes your child upset, frustrated, angry? _____

_____

How does your child calm down? _____

_____

What makes your child happy? _____

_____

TREATMENT PLANNING

What would you like to see your child accomplish with therapy? _____

_____

_____

_____