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? ______________________________

____

____

____