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PARENT/CAREGIVER QUESTIONNAIRE

GENERAL INFORMATION **Date:** _____

Child's Name: _____ *Age:* _____

Date of Birth: _____ *Gender:* _____

Parent 1 Occupation: _____ *Level of Education:* _____

Parent 2 Occupation: _____ *Level of Education:* _____

PATIENT HISTORY

Who referred you for this evaluation? _____

Why did they refer you? _____

What are your main concerns? _____

_____

What are your goals for therapy? _____

When was the problem first noticed?

_____

Is your child aware of the problem? **Yes** **No**

If yes, how does your child feel about it? _____

_____

How would you describe your child? _____

_____

What are your child's strengths? _____

_____

Does your child have any special interests? _____

_____

Does your child use any type of adaptive equipment? _____

_____

FAMILY INFORMATION

List all people in household:

Name	Age	Sex	Grade	Relation

Is there family history of motor or sensory concerns? ***Yes*** ***No***

*If yes, please describe:*_____

What language(s) does your child speak? _____

What language(s) are spoken in the home? _____

HEALTH & MEDICAL HISTORY

Has your child ever been examined by any other professionals? **Yes** **No**

Who	Date Seen	Findings/Results
Developmental Pediatrician		
ENT		
GI		
Neurologist		
Pediatrician		
Psychologist		
Psychiatrist		

Is your child currently on any medications? ***Yes*** ***No***

Name	Dosage	Frequency	Purpose

How is your child's general health? _____

_____

Please list any health conditions, surgeries, etc. of note: _____

Has your child had any ear trouble (ear aches, infections)? **Yes** **No** *#?* _____

Has hearing been tested? **Yes** **No** *Date:* _____

Has your child ever had (PE) tubes inserted? **Yes** **No** *Date:* _____

Has your child ever worn glasses? **Yes** **No**

Has your child had any seizures? **Yes** **No**

Were there any noticeable changes in your child's general behavior, motor skills, or sensory development after certain life events, illnesses, surgeries, etc.? **Yes** **No**

If so, explain: _____

_____

*Does your child have any known **skin** allergies?* **Yes** **No**

To Latex? **Yes** **No**

*Does your child have any **food** allergies or is s/he on a restricted diet?* **Yes** **No**

If so, please explain: _____

_____

BIRTH HISTORY

Is the child adopted? Yes No *At what age?* _____

Complications or illnesses during pregnancy? **Yes** **No**

Medication taken during pregnancy? **Yes** **No**

If yes, please list: _____

Weight at birth _____

Was delivery?	**Premature**	**Full-term**	**Late**	
Type of Birth:	**Vaginal**	**Caesarean**	**Breech**	
Did baby require:	**Oxygen**	**Tube Feed**	**Transfusions**	**NICU**

DEVELOPMENTAL HISTORY AND INFORMATION:

MOTOR:
Please indicate if motor milestones were met on time or delayed:

	On Time	Delayed
Lift Head		
Roll over		
Sit Unsupported		
Stand alone		

Crawl on all fours		
Walk independently		
Bladder Trained		
Bowel trained		

Does your child display hand dominance? **Yes** **No**
Right **Left** **No preference**

Can your child point using finger isolation? **Yes** **No**
Does your child use a point independently? **Yes** **No**
Does your child resist tooth brushing? **Yes** **No**

Does your child have difficulty learning new motor skills: **Yes** **No**
Can your child imitate motor skills? **Yes** **No**
Please circle which one(s): *Waving* *Stomping Feet* *Arms Up*
Clapping *Roll Ball* *Arms Out*
Pointing *Peek-A-Boo* *Thumbs Up*
Head Nod *Head Shake* *Jump*
Open Mouth

Is your child clumsy or uncoordinated? **Yes** **No**
Does your child have difficulties with handwriting? **Yes** **No**
Does your child fatigue easily? **Yes** **No**
Does s/he drool? **Yes** **No**

SENSORY PROCESSING:

	Frequently	**Sometimes**	**Never**	**Comments**
In constant motion or unable to sit still?				
Trouble concentrating or can't stay on task				
Always runs, jumps, or stomps rather than walking				
Bumps into things or frequently knocks things over				
Reacts strongly to being touched/bumped				
Avoids messy play/ Doesn't like to get hands dirty				
Hates having hair washed, brushed, or cut				
Hates having fingernails cut				

Resists wearing new clothing or bothered by tags/socks				
Hesitates to play or climb on playground equipment				
Distressed by loud or sudden sounds				
Difficulties with balance				
Loses place when reading or copying from the board				
Difficulty tracking objects with eyes				
Mood variations, outbursts and tantrums				
Difficulty calming down				
Avoids eye contact				
Trouble following multistep instructions				
Picky eater				
Often gags on food				
Reacts strongly to smells				
High Pain threshold				
Low Pain Threshold				

Does your child show aversive reaction to touching certain objects or textures? ***Yes*** ***No***

___ *on hands*
___ *on mouth/lips*
___ *on face*
___ *on feet*
___ *on body*
___ *inside mouth*

SELF-HELP

Please check any of the following your child CAN do:

Eating/Drinking

___ *Suck from a bottle*
___ *Suck from a straw*
___ *Drink from a cup held for him/her*
___ *Hold and drink from a sippy cup*
___ *Hold and drink from an open cup*
___ *Feed self without help*
___ *Drinks with:* **much spilling** **little spilling**
___ *Finger feed*
___ *Hold a spoon*
___ *Scoop with a spoon*
___ *Use a fork*
___ *Use a knife to spread*
___ *Use a knife to cut*
___ *Eats with*: **much spilling** **little spilling**

no spilling **no spilling**

Do they use utensils at every meal/snack? **Yes** **No**
Do they need reminders? **Yes** **No**
Does your child refuse to use utensils/only finger feeds? **Yes** **No**

DRESSING:

Can your child button? **Yes** **No**
Can your child unbutton? **Yes** **No**
Can you child zip clothing? **Yes** **No**
Can your child tie shoes? **Yes** **No**

Please indicate your child's skills in dressing:

	PUT ON	REMOVE	Independent	Assistance Needed
Shoes				
Socks				
Shirt				
Pants				
Underwear				
Jacket				

COMMUNICATION AND ATTENTION:

How does your child communicate? (check all that apply)

Eye contact **Moves person/adult**
Gestures **Vocalizations**
Sign Language **AAC device**
Verbally

Can your child follow directions? **Yes** **No**

1 step **2 steps** **3 steps**

Please rate your child's attention:

Preferred tasks **Good** **Fair** **Poor**
Non Preferred tasks **Good** **Fair** **Poor**
Academic tasks **Good** **Fair** **Poor**
During interactions with others **Good** **Fair** **Poor**

EDUCATIONAL HISTORY

Name of current school: _____

Current grade: _____

*Indicate performance level in schoo*l: **Above Average** **Average** **Below Average**

Previous Schools/Daycares:_____

Does your child receive: **Tutoring** **IEP** **504 plan**

THERAPY:

Please provide information on therapies your child currently receives.

Therapy	***How often?***	***When began?***	***Therapist Name***	***Location***
Speech				
Physical Therapy				
Applied Behavior Analysis				
Floor Time				
Music				
Nutrition				
Other				

BEHAVIOR/SOCIAL:

Does your child play: **Alone** **with older kids** **with peers** **with younger kids**

Does your child have close friends? **Yes** **No**

*What are your child's most frequent discipline problems?*_____

_____

Who handles discipline? _____

How is your child disciplined? _____

*What does your child do well?*_____

_____

What does your child have trouble doing? _____

_____

Is there anything else you would like us to know?

_____

_____

_____