Milestone Pediatric Therapy Services, Inc

40 Professional Drive Jefferson, GA 30549

Phone: 706-367-1141 Fax: 706-367-1142

**OT Questionnaire**

**Child’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_ M/F:**

**Current Diagnosis:**

**Home Address:**

**Home Phone:**

**Preferred E-mail Address:**

**School Attended: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Grade:**

**Parent #1 name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation:**

**Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone:**

**Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent #2 name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation:**

**Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone:**

**Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:**

**Phone:**

**Primary Language:**

**Language Spoken at Home:**

**Child’s Primary Physician:**

**Address/Phone:**

**Child’s Referring Physician:**

**Address/Phone:**

**Reason for Referral:**

 **What are your primary areas of concern/What are you hoping for the Occupational Therapist to address?**

 **What are your goals for Occupational Therapy?**

**Please list any Medical Precautions/Allergies/Medications**

**Is your child receiving any other services (i.e. Speech, Physical Therapy, Special Education, Early Intervention)?**

**What (if any) special equipment does your child use?**

**Wheelchair: \_\_\_Eye glasses: \_\_\_\_Hearing Aids: \_\_\_\_\_ Braces: \_\_\_\_\_**

**Walker: \_\_\_\_\_**

**Communication Device: \_\_\_\_\_ Crutches: \_\_\_\_\_ Other: \_\_\_\_\_**

**Prenatal & Birth History:**

Please list any significant prenatal or birth history *(weeks gestation, birth weight, APGARS)*:

**Premature& Birth History:**

Please list any significant prenatal or birth history *(weeks gestation, birth weight, APGARS)*:

\_\_\_Premature \_\_\_Vacuum Delivery

\_\_\_Full term \_\_\_Preeclampsia

\_\_\_Low birth weight \_\_\_Gestational Diabetes

\_\_\_IUGR \_\_\_Breast fed

\_\_\_Weeks Gestation \_\_\_Poor suction/latch

\_\_\_Breech Birth \_\_\_Bottle fed

\_\_\_C-section Birth (planned) \_\_\_Multiple Ultrasounds

\_\_\_Emergency C-section \_\_\_Oxygen at Birth

\_\_\_Vaginal Birth \_\_\_NICU stay \_\_\_Duration in NICU\_\_\_\_

\_\_\_Forceps Delivery \_\_\_Other:\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History:**

Please list any significant illness, hospitalizations, etc… :

\_\_\_Chronic ear infections \_\_\_Colic \_\_\_Asthma

\_\_\_Tubes \_\_\_Poor sleep \_\_\_Frequent antibiotic use

\_\_\_Tonsils/Adenoid Surgery \_\_\_Asthma \_\_\_Frequent fevers

\_\_\_ Compromised Immune System \_\_\_Reflux \_\_\_ Lyme disease

\_\_\_Surgeries: **list above** \_\_\_Abnormal muscle tone \_\_\_Abnormal Lab results

\_\_\_Poor weight gain \_\_\_Torticollis \_\_\_Cardiac Issues

**Developmental History:**

Fill in the blanks to describe your child to the best of your ability:

Sat at \_\_\_months/years

Crawled at \_\_\_months/years

Stood at \_\_\_months/years

Walked at \_\_\_months/years

Ran at \_\_\_months/ years

Talked at \_\_\_months/ years

Dressed at \_\_\_months/ years

Toilet trained at \_\_\_months/ years

Fed self \_\_\_months/years

\_\_\_Was not placed on his/her belly as an infant

\_\_\_Was placed on his/her belly as an infant

\_\_\_Enjoyed belly time as an infant

\_\_\_Is athletic/ plays sports

\_\_\_Did not tolerate being placed on his/her belly as an infant

\_\_\_Is good negotiating playground equipment

\_\_\_Met all motor milestones on time

\_\_\_Is good with his/her hands (fine motor skills)

\_\_\_Was/is developmentally delayed

\_\_\_Was late to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Is clumsy \_\_\_Avoids climbing, swinging, sliding

Please list any motor development concerns you have (i.e. gross motor, fine motor, oral motor, motor planning, fear of movement, fear of heights, etc…):

**Academic History:**

Check off all that apply to your child:

\_\_\_Does well in school

\_\_\_Does well with the exception of:

\_\_\_Is challenged by school

\_\_\_Is challenged by writing

\_\_\_Is challenged by reading

\_\_\_Is not enrolled in school

\_\_\_Receives resource/ tutoring for:

\_\_\_Is an **A B C D F** Student

\_\_\_Is in a self-contained classroom

Please list any academic concerns you have:

Please list any specific teacher concerns:

**Behavior/Social History:**

Check off all that apply to your child

\_\_\_Is social and engaging \_\_\_Does not like new places/ people

\_\_\_Makes good eye contact with adults and peers \_\_\_Does not like crowds

\_\_\_Is well behaved \_\_\_Has difficulty with transitions

\_\_\_Pays attention \_\_\_Prefers to play alone

\_\_\_Listens well \_\_\_Has difficulty paying attention

\_\_\_Follows directions well \_\_\_Has difficulty listening

\_\_\_Plays well with other children \_\_\_Is very busy and active

\_\_\_Is easy going \_\_\_Poor coping skills

\_\_\_Does well with change \_\_\_Unable to self-calm

\_\_\_Understands safety \_\_\_Extremely sensitive to criticism

\_\_\_Takes turns with peers \_\_\_ Is oppositional

\_\_\_ Quickly escalates without apparent cause \_\_\_Is aggressive

Please list any behavioral or social concerns:

**Evaluation & Therapy Services:**

Please list any previous occupational therapy evaluations completed and recommendations:

Please list any previous psychological/neuropsychological/psych-educational evaluations completed and recommendations:

**My signature below is confirmation that I have informed Milestone Pediatric Therapy Services of all necessary information and have answered all questions truthfully and to the best of my ability.**

Parent Signature

Print Name

Patient Name