Milestone Pediatric Therapy Services, Inc
510 Panther Dr Jefferson, GA 30549
740 Prince Ave Bldg 2 Athens, GA 30606
Phone: 706-367-1141 Fax: 706-932-0206

OT QUESTIONNAIRE

Childs Name:

Nickname:

Address:

City/State/Zip:

Phone Number:

Date of Birth:

Today's Date:

Age:

Parents/Caregivers Names:

How/From whom were you referred?

What are your current concerns?

A. MEDICAL HISTORY:

1. Does the child currently have a medical diagnosis? If so, please list/describe (please include history of chronic conditions, i.e. congestion/ear infections).

2. Who is the child's current pediatrician?

3. Has the child ever had surgery or been hospitalized for any reason? Please list.

4. Is the child currently taking any medications? Please list.

5. Does the child have any known allergies? (medication, foods, latex, seasonal, etc.)

6. Has the child's hearing been evaluated? YES ___ NO___

If so: Where __________ When _________ Status_________

Frequent Ear Infections?

Tubes in his/her ears?

Currently being treated for ear infections?

7. Has the child's vision been evaluated? YES_____ NO_____

If so, Where __________ When __________ Status____________

Does your child require glasses?

Suspected vision issues?

B. BIRTH HISTORY:

1. Was child born full term? If not, indicate weeks of prematurity.

2. List any complications surrounding the birth/pregnancy.

3. Did your child come directly home from hospital or stay for any reason (NICU, etc.). Please indicate reason and duration if applicable.

4. Breast, bottle , or combo fed?

Any issues or concerns with latching, feeding?

C. DEVELOPMENTAL HISTORY:

1. At what age did your child do the following:

Sit up alone ________ Crawl on all fours ________ Walk alone _________

Toilet trained _________ Say first word ___________

2. Has your child ever had any difficulty eating (chewing, swallowing, stuffing, pocketing, picky, food aversions, cup use)?

3. Does your child have an active or lingering thumb-sucking, finger sucking, or pacifier habit?

4. How would you describe your child as an infant (alert/active, difficult to calm, resistant or likes to be held, good or irregular sleep patterns, fussy or irritable, excessive crying, tense or floppy when held, responsive to surroundings)?

D. FAMILY HISTORY:

1. List who is currently in the child's immediate living environment

2. Is there a family history of speech, language, learning, hearing, sensory, motor or mental health issues (ADD, anxiety, etc.)?

E. SCHOOL/THERAPY HISTORY:

1. Does your child currently attend school, daycare, playgroup, etc.? If so, indicate where and how long each week.

2. Is your child having any difficulties at school (academically, behaviorally, etc.)?

3. Has your child ever received any type of therapy (speech./language, occupational, physical)? If so, indicate which and durations.

4. Does your child currently have an IFSP, IEP, or 504 plan? If so, please provide most recent copy.

F. SOCIAL/PLAY/ BEHAVIOR / COMMUNICATION

1. List your child's preferred play activities:

2. Does your child…

Engage in pretend play?

Play with toys appropriately?

Take turns in play?

Play with or alongside other children?

Make adequate eye contact?

Seek out others for interaction?

3. How does your child currently communicate their wants/needs?

4. Does your child follow directions? If so, how many steps? If not, describe

5. Do you have difficulty understanding your child? If so, describe.

G. READING/WRITING HISTORY:

1. Does your child have an interest in books? Describe.

2. Describe your child's current literacy/writing status (reading, recognizing letters, tracing, etc.)

H. ADL/SELF-HELP SKILLS:

1. Do you have any concerns with independent functioning?

2. Eating: Indicate yes/no, can the child…

Feed self finger food?

Stab food with fork?

Bring spoon to mouth?

Scoop food with spoon?

Cut food with knife?

Feed self independently?

3. Dressing: Indicate yes/no, Can the child independently…

Take off clothes (shirt, pants, shoes, socks, coat)?

Put on clothes (shirt, pants, shoes, socks, coat)?

Fasten small buttons, large buttons, or snaps?

Zipper up/down?

Tie shoes?

I. MOTOR/SENSORY SKILLS:

1. Do you have concerns regarding gross motor skills (i.e. walking, jumping, running, balance, ball skills, physical activities)? If yes, describe.

2. Has your child ever had difficulty with body awareness and/or coordination with movement (i.e. appears clumsy, grasps objects too light or too tight, moves very fast or slow, frequent falling, etc.)?

3. Did your child show delays in onset of independent sitting, crawling, or walking skills?

4. Do you have concerns regarding fine motor skills (i.e. holding pencil correctly, manipulation of objects, scissor skills, coloring within the lines)? If yes, describe.

5. Do you have concerns regarding your child's handwriting skills (i.e. poor spacing of words, reversals of letters/numbers, mastering cursive, etc.)? If yes, describe.

6. Has your child ever had difficulty with sensory issues (i.e. respond differently to touch, noise, or smells; crave rough play or touch, bump into objects; not like to get messy; seem fearful of movement)? If yes, describe.

7. Does your child have difficulty staying focused/on-task as compared to same-aged peers? If yes, describe.

J. THERAPY GOALS:

1. What are your current occupational therapy related goals/expectations for your child? Do you wish to pursue occupational therapy if needed?

2. If yes, what are your preferred/available times to bring the child to therapy?

3. Are there any issues (language, religious, cultural, food restrictions, etc.) that may interfere with therapy?

4. PLEASE PROVIDE ANY ADDITIONAL INFORMATION THAT MAY BE HELPFUL TO THE EVALUATION/TREATMENT PROCESS:

COMPLETED BY: ___________________________

RELATIONSHIP_____________________________.

DATE _____________________________________