Milestone Pediatric Therapy Services, Inc
514 Panther Drive Jefferson, GA 30549
Phone: 706-367-1141 Fax: 706-367-1142

Occupational Therapy Questionnaire

Child's name: _____ DOB: _____ Age: _____ M/F:

Current Diagnosis:

School Attended: _____Grade:

Emergency Contact: _____ Relationship:
Phone:

Primary Language:
Language Spoken at Home:
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
____Full term
____Low birth weight
____IUGR
____Weeks Gestation
____Breech Birth
____C-section Birth (planned)
____Emergency C-section
____Vaginal Birth
____Forceps Delivery
____Vacuum Delivery
____Preeclampsia
____Gestational Diabetes
____Breast fed
____Poor suction/latch
____Bottle fed
____Multiple Ultrasounds
____Oxygen at Birth
____NICU stay ____Duration in NICU_____
____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…):

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:

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
____Makes good eye contact with adults and peers
____Is well behaved
____Pays attention
____Listens well
____Follows directions well
____Plays well with other children
____Is easy going
____Does well with change
____Understands safety
____Takes turns with peers
____ Quickly escalates without apparent cause
____Does not like new places/ people
____Does not like crowds
____Has difficulty with transitions
____Prefers to play alone
____Has difficulty paying attention
____Has difficulty listening
____Is very busy and active
____Poor coping skills
____Unable to self-calm
____Extremely sensitive to criticism
____ Is oppositional
____Is aggressive

Please list any behavioral or social concerns:

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 Patient Name Date