

Greater Atlanta Speech and Language Clinics

1515 Johnson Ferry Road
Suite 100
Marietta, Georgia 30062
Phone: (770) 977-9457
Fax: (770) 977-5087



Working Together for a Greater Tomorrow

Mindy C. Elkan, M.A., CCC
Clinical Director
Michelle Needle, M.Ed., CCC
Assistant Director

CONFIDENTIAL PARENT QUESTIONNAIRE FOR PHYSICAL/OCCUPATIONAL THERAPY EVALUATION

A. Patient Information:

1. Child's Name: _____ Gender: _____
2. Date of Birth: _____ Age: _____
3. Diagnosis or reason for referral: _____
4. Referred by: _____
5. List other professionals who have evaluated your child and any diagnosis made (include dates):

B. History. Please complete as much of the following information as you can (if your child was adopted or in foster care, please check here

1. Was this the first pregnancy? _____
2. How many before this? _____
3. Any illnesses or problems during pregnancy? _____

4. Were there problems with other pregnancies before this one? _____ If so, explain: _____

5. List medications or drugs taken during pregnancy: _____
6. Was the baby born early? late? How many weeks early/late: _____
7. Baby's weight at birth _____
8. Describe any problems during delivery: _____

9. Was the baby released from hospital with mother? If not, how long was the baby in the hospital?

10. At the time of the child's birth, mother's age was _____ father's age was _____.

11. List all persons who live with the child and ages: _____

12. Describe any illnesses, feeding, sleeping, or behavior problems during the first few months of life:

13. Did your child experience any of the following (if so, at what age)?

Jaundice	_____	Colic	_____	Measles	_____
Mumps	_____	Rubella	_____	Pneumonia	_____
Croup	_____	Other	_____		

14. Does your child have any of these problems (please check/list)?

_____ asthma _____ seizures _____ headaches

Food allergies: _____

Other allergies: _____

Any injuries or surgery: _____

15. List any health precautions, limitations or diet restrictions: _____

C. DEVELOPMENTAL HISTORY:

1. Motor/Sensorimotor. At what age did your child:

_____ Lift head while on stomach	_____ Drink from a straw
_____ Roll over front to back	_____ Drink from a cup without help
_____ Sit alone	_____ Use a spoon
_____ Crawl on all fours	_____ Stop wearing diapers during the day
_____ Stand alone	_____ Pedal a tricycle
_____ Walk holding on to the furniture	_____ Ride a bike
_____ Walked independently	_____ Walk down stairs unassisted
_____ Give up a bottle during the night	

2. Please describe any differences you noticed in your child's motor development from other children at the same age: _____

3. What movement activities does your child like? _____

4. What activities does your child avoid? _____

5. Does he/she seem overly sensitive to (check):

Begin touched _____

Being hugged _____

Having face washed or hair cut _____

Eating certain foods, flavors or textures _____ (list) _____

Wearing certain clothes _____ (list) _____

6. Does he/she avoid:

Touching things or getting dirty? _____

Cover ears or hide head around certain noises? _____

Blink excessively or blink when a ball is thrown to him/her? _____

7. Can your child throw a ball? _____ Catch a ball? _____

8. Which hand is used most often? _____

9. Do you feel your child's hand skills are delayed? _____

10. Please list the hand skills you feel are difficult for him/her to do: _____

D. Self Help - Please check any of the following your child CAN do.

1. Eating:

____ Suck from a bottle/straw

____ Drink from a cup held for him/her

____ Hold and drink from a cup with sipper top _____ Without a top

____ Finger feed

____ Feed self without help

____ Hold a spoon

____ Scoop with a spoon

____ Use a fork

____ Use a knife to spread _____/to cut

____ Eats with much spilling _____/little spilling _____/no spilling

Describe any special equipment/help needed:

2. Dressing: (Yes, no, needs help)

Removes: shoes _____ shirt/jacket _____ pants _____ underpants _____
Puts on: shoes _____ shirt/jacket _____ pants _____ underpants _____

Describe any help needed: _____

3. Hygiene: (Please describe any specific help or special equipment needed with):

Bathing _____

Tooth brushing _____

Toileting _____

E. Psychological and Play

1. Other than TV/computer does your child have difficulty:

Paying attention? _____

Sticking to one activity for 2-3 minutes? _____ for 15-20 minutes? _____

2. Does your child:

Have difficulty switching activities? _____

Have rituals or need to do things the same way each time? _____

Become frustrated easily? _____

Have tantrums? _____ Hit/bite? _____

3. Describe any other behavior problems you have with your child: _____

4. What disciplinary methods do you use? _____

5. Does your child have many friends? _____

6. Does he/she prefer to play with older children? _____ Younger children? _____ Alone? _____

7. What are your child's favorite play activities toys, games etc.? _____

8. Does your child have unusual fears? _____ Preoccupations? _____

9. Has he/she had any evaluations for behavioral or emotional problems? _____ If so, by whom
and when? _____

10. Please check any terms that apply to your child:

- | | | | |
|--------------------------------------|---|--|--|
| <input type="checkbox"/> Shy | <input type="checkbox"/> Friendly | <input type="checkbox"/> Cooperative | <input type="checkbox"/> Creative |
| <input type="checkbox"/> Nervous | <input type="checkbox"/> Overly talkative | <input type="checkbox"/> Jealous | <input type="checkbox"/> Thumb sucker |
| <input type="checkbox"/> Nail biter | <input type="checkbox"/> Destructive | <input type="checkbox"/> Angry | <input type="checkbox"/> Aggressive |
| <input type="checkbox"/> Ritualistic | <input type="checkbox"/> Rocks | <input type="checkbox"/> Head banger | <input type="checkbox"/> Poor tolerance for change |
| <input type="checkbox"/> Bites | <input type="checkbox"/> Fidgety | <input type="checkbox"/> Affectionate | <input type="checkbox"/> Short attention span |
| <input type="checkbox"/> Lazy | <input type="checkbox"/> Overly active | <input type="checkbox"/> Absent minded | <input type="checkbox"/> Lacks self confidence |
| <input type="checkbox"/> Cuddler | <input type="checkbox"/> Picky eater | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Rarely shows emotion |
| <input type="checkbox"/> Daydreams | <input type="checkbox"/> Avoids eye contact | <input type="checkbox"/> Looks through you | <input type="checkbox"/> Good self esteem |

Other: _____

F. Educational

1. Please list all schools or daycare situations your child has attended:

2. Current school placement (or expected fall placement): _____

3. Grade or class: _____ teacher: _____

4. Does your child receive any form of special education? _____

5. Special education teacher's name: _____

6. Describe any problems your child has had at school: _____

7. Does your child receive or are you seeking out any other therapy? _____

8. Please provide therapist names, etc.

Therapist	Type of Therapy	Location	Date began
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

G. Speech and Hearing

- 1. Has your child had his/her hearing tested? _____ What were the results? _____
- 2. Did your child babble or coo? _____ Did it increase after 6 months? _____
- 3. Could you distinguish various types of cries? _____
- 4. When did he/she:
Speak first word? _____
Put two words together? _____
Speak in short sentences? _____
- 5. Do you think your child currently speaks as well as other children of the same age? _____
- 6. How does your child let you know what he/she wants? _____

7. Please check any terms that apply to your child:

- | | | |
|--|---|---|
| <input type="checkbox"/> No speech present | <input type="checkbox"/> Rarely speaks | <input type="checkbox"/> Lack of response when spoken to |
| <input type="checkbox"/> Speaks too fast | <input type="checkbox"/> Keeps mouth open | <input type="checkbox"/> Often seems to ignore when being spoken to |
| <input type="checkbox"/> Speaks too softly | <input type="checkbox"/> Drools | <input type="checkbox"/> Can't begin speaking easily or stutters |
| <input type="checkbox"/> Speaks too loud | <input type="checkbox"/> Tongue thrust | <input type="checkbox"/> Speech is not understandable |
| <input type="checkbox"/> Voice is hoarse | <input type="checkbox"/> Talks too much | <input type="checkbox"/> Talks but can't get to the point |
| <input type="checkbox"/> Voice is nasal | <input type="checkbox"/> Can't find the words | <input type="checkbox"/> Difficulty chewing or swallowing |
| <input type="checkbox"/> High pitch | <input type="checkbox"/> Yells | <input type="checkbox"/> Complains of ear pain |

Other:

H. How do you hope we can help you and your child?

(continued on next page)

SENSORIMOTOR HISTORY

Place an X in the appropriate column, items marked "yes" may indicate sensorimotor problems.

**TACTILE
SENSATION**

QUESTIONS	NO	YES	COMMENTS
Does the child:			
1) Object to being touched?			
2) Dislike being cuddled?			
3) Seem irritable when held?			
4) Prefer to touch rather than be touched			
5) React negatively to the feel of new clothes?			
6) Dislike having hair and / or face washed?			
7) Prefer certain textures of clothing?			
8) Avoid certain textures of food?			
9) Isolate self from other children?			
10) Frequently bump and push other children?			

**AUDITORY
SENSATION**

Does the child:			
1) Seem overly sensitive to sound?			
2) Miss some sounds?			
3) Seem confused about the direction of sounds?			
4) Like to make loud noises?			
5) Have a diagnosed hearing loss?			

**OLFACTORY
SENSATION**

Does the child:			
1) Explore the environment with smell?			
2) Discriminate odors?			
3) React defensively to smell?			
4) Ignore noxious odors?			

**VISUAL
SENSATION**

Does the child:			
1) Have a diagnosed visual defect?			
2) Have difficulty eye-tracking?			
3) Make reversals when copying?			
4) Have difficulty discriminating colors, shapes?			
5) Appear sensitive to light?			
6) Resist having vision occluded			
7) Become excited when confronted with variety of visual stimuli?			

**GUSTATORY
SENSATION**

Does the child:			
1) Act as though all food tastes the same?			
2) Explore by tasting?			
3) Avoid foods with a lot of flavor?			

**VESTIBULAR
SENSATION**

Does the child:			
1) Dislike being tossed in the air?			
2) Seem fearful in space (i.e. going up and down stairs, riding teeter-totter)?			
3) Appear clumsy, often bumping into things and/or falling sown?			
4) Prefer fast-moving, spinning carnival rides?			
5) Avoid balance activities?			

**MUSCLE
TONE**

Does the child:			
1) Have any diagnosed muscle pathology (i.e. spasticity, flaccidity, rigidity, etc.)?			
2) Seem weaker or stronger than normal?			
3) Frequently grasp objects too tightly?			
4) Have a weak grasp?			
5) Tire easily?			

COORDINATION

Does the child:			
1) Manipulate small objects easily?			
2) Seem accident prone? (i.e. have frequent scrapes and bruises)?			
3) Eat in a sloppy manner?			
4) Have difficulty with pencil activities?			
5) Have difficulty dressing and / or fastening clothes?			
6) Have a consistent hand dominance?			
7) Neglect one side of the body or seem unaware of it?			

**REFLEX
INTEGRATION
AND
DEVELOPMENT**

1) Was the child slow to reach the usual developmental milestones (i.e. sitting, walking, talking)?			
2) Was the child irritable in infancy, particularly when held?			
3) Does the child have difficulty isolating head movement?			
4) Does the child lack adequate protective reactions when falling?			