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

Greater Atlanta Speech and Language Clinics

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 <u>CAN</u> 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:

__	Shy	__	Friendly	__	Cooperative	__	Creative
__	Nervous	__	Overly talkative	__	Jealous	__	Thumb sucker
__	Nail biter	__	Destructive	__	Angry	__	Aggressive
__	Ritualistic	__	Rocks	__	Head banger	__	Poor tolerance for change
__	Bites	__	Fidgety	__	Affectionate	__	Short attention span
__	Lazy	__	Overly active	__	Absent minded	__	Lacks self confidence
__	Cuddler	__	Picky eater	__	Poor appeetite	__	Rarely shows emotion
__	Daydreams	__	Avoids eye contact	__	Looks through you	__	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:

__ No speech present
__ Speaks too fast
__ Speaks too softly
__ Speaks too loud
__ Voice is hoarse
__ Voice is nasal
__ High pitch
__ Rarely speaks
__ Keeps mouth open
__ Drools
__ Tongue thrust
__ Talks too much
__ Can't find the words
__ Yells
__ Lack of response when spoken to
__ Often seems to ignore when being spoken to
__ Can't begin speaking easily or stutters
__ Speech is not understandable
__ Talks but can't get to the point
__ Difficulty chewing or swallowing
__ 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.

	QUESTIONS	NO	YES	COMMENTS
TACTILE SENSATION	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-tooter)?			
	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?			