NATURAL PAIN MANAGEMENT AND WELLNESS

PARENT QUESTIONNAIRE OCCUPATIONAL THERAPY SERVICES

Please return as soon as possible. The information you give us will help us to understand your child and to better plan for his/her visit. Not all questions may apply to your child.

Child name: _____
Today's date:_____
Child DOB:_____
Gender:_____
Insurance:_____
Address:_____
_____
Phone: _____
Email:_____

Diagnosis (if any):

_____

Person completing questionnaire:

_____

Relationship to child: _____

Brothers/Sisters (Include names and ages):

_____

Who referred you for this evaluation?

_____

Child's Primary Care Provider Contact Info

_____

What are your main concerns about your child?

_____

_____

_____

What are your goals for therapy?

_____

_____

What are your child's strengths?

_____

_____

Were there any problems during your pregnancy? Yes No

Were there any problems during your child's birth? Yes No

Has your child had any significant illnesses, injuries, and/or hospitalizations? Yes No

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If yes to any of the above, please describe:

_____

_____

_____

List any medications currently taken by your child:

_____

Does your child have any allergies? Yes No

If yes, please list:

_____

Is your child on a specific diet or food restrictions? Yes No

If yes, please list:

_____

Does your child have regular sleeping habits or good ability to fall and stay asleep? Yes No

If no, please describe:

_____

_____

Does your child receive early intervention services through the school district? Yes No

Does your child currently attend school? Yes No

Name of School/Grade:

_____

Does your child have a current Individual Education Plan (IEP) or Individual Family Service Plan (IFSP)? Yes No

Is your child currently receiving any other healthcare services (i.e. PT, speech, psych, etc)?

_____

Please list approximate ages that your child accomplished major developmental milestones:

Head/neck control: _____

Rolling: _____

Sitting: _____

Crawling: _____

Natural Pain Management and Wellness

Walking: _____

Talking: _____

Does your child communicate verbally? Yes No

If your child is non-verbal, describe how do they communicate with you?

_____

Check level of performance your child is able to complete:

Dressing Skills:

Child can independently dress self? Yes No

Child can zip and button clothing? Yes No

Child needs occasional assistance to dress? Yes No

Child is starting to push arms through sleeves; legs through pant legs? Yes No

Parent dresses child on a daily basis? Yes No

Comments:

_____

Feeding Skills:

Do you have concerns about your child's eating habits? Yes No

Child is a very picky eater will only eat certain foods or textures? Yes No

Child uses spoons/forks at every meal? Yes No

Occasionally or needs reminders to use utensils? Yes No

Never uses utensils. Yes No

Child eats an adequate amount of food for his/her age? Yes No

Child is willing to sit at table/highchair for all meals. Yes No

Comments:

_____

Motor Skills:

Child appears clumsy or uncoordinated? Yes No

Child has difficulties with handwriting? Yes No

Child has established hand dominance? Yes No

Child fatigues easily and has poor endurance? Yes No

Child has difficulties learning new motor skills? Yes No

Comments:

Social Interactions:

Does your child play with age appropriate toys? Yes No

Does your child respond when his/her name is called? Yes No

Does your child have difficulties with transitions to new activities/environments? Yes No

Does your child have difficulties with changes in routine? Yes No

Does your child have poor frustration tolerance? Yes No

Does your child have poor safety awareness in the community? Yes No

If your child is upset or angry do they have difficulties calming and coping with anger? Yes No

Comments:

Do you have concerns about your child's ability to play with other children? Yes No

Please describe:

Sensory Processing:

Does your child have significant fear, aversion or difficulties with the following items?

Washing/cutting hair: Yes No

Cutting finger nails: Yes No

Brushing teeth/oral care: Yes No

Loud and unexpected sounds: Yes No

Clothing textures/fabric: Yes No

Avoids swings/climbing/movement: Yes No

Avoids messy play/getting dirty: Yes No

Difficulties with calming down: Yes No

Difficulties focusing attention: Yes No

Engages in risky play activities: Yes No

Prefers rough play: Yes No

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Child craves movement: Yes No

Child is constantly moving “on the go”: Yes No

Any other comments or questions you have for the therapist:

_____

_____