OCCUPATIONAL THERAPY EVALUATION QUESTIONNAIRE

1. Reason for OT referral?

2. Which of these does your child do by him/herself? Which is of the most concern?

    a. Dress
    b. Bathe
    c. Brush teeth
    d. Use of toilet
    e. Eat with utensils

3. Does your child have difficulty sleeping?

4. Does your child perform any type of self stimulatory behavior? (i.e. rocking, biting self, hand flapping, head bobbing, licking/eating nonedibles, humming, constantly running about aimlessly, opening and closing doors/objects, etc.)

5. Does your child wear hand or arm splints? If so, **PLEASE BRING TO SESSION**

6. Does your child go to preschool/Headstart or daycare? If so,

    a. Where?
    b. How often?
    c. Do they receive OT services at school?
        i. Therapists name____________________

7. Is there an issue that seems unrealistic that may prevent your child from attending school at all or the classroom you consider most appropriate?

8. Is your child on medication? Please list name, what it is for, and side effects (if any).

9. Are there any other problems/difficulties that we should be aware of before the evaluation? (i.e. vision, hearing, motor, behavior)

10. Has your child had any other evaluations? (i.e. ST, PT, psychological, audiological, etc.)

11. Has you child received ST, OT or PT in the past year? YES NO If yes, when did it begin and end?

PLEASE BRING A COPY OF ANY REPORT(S) TO THE EVALUATION