

Occupational Therapy Parent Information Form

****Please complete this form and fax or email to the St. John's Child Development Center before your appointment.****

Child's Name: _____ Sex: Male or Female

Date of birth: _____

Parents' Names: _____

Address: _____

Phone Number: Home: _____ Cell: _____ Other: _____

Mother's Occupation: _____ Employer: _____

Work hours: _____ Work phone: _____

Father's Occupation: _____ Employer: _____

Work hours: _____ Work phone: _____

Members of Household

Marital status of parents: Married Divorced Separated Other

Other family members, please include names and ages:

Pediatrician: _____ Phone Number: _____

Address: _____

Reason for Referral: _____

Who referred you to the Child Development Center? _____

Medical History

Birth Weight: ___lbs___oz ___ Full Term ___ PreTerm- how many weeks early?_____

Please list any complications during pregnancy, delivery, or birth: _____

Please list any significant illness and/or surgeries: _____

Medications: ___yes ___no

*****please list prescription/"over the counter", herbal supplements, or vitamins*****

Medical Diagnosis: _____

Last physical exam date: _____ Results: _____

Please list any other professionals consulted for your child (i.e., neurologist, psychologist, orthopedist, nutritionist, GI)? _____

Allergies to substances, medicines, or foods: _____

History of ear infections ___yes ___no tubes in ears? ___yes (___right ___left) ___no

Hearing testing ___yes ___no testing date: _____ results: _____

Vision testing ___yes ___no testing date: _____ results: _____

Glasses or contacts: _____

Special diet(s) ___yes ___no please list: _____

Nutritionist ___yes ___no if yes, reason: _____

Has your child previously had:

___ Occupational Therapy
Agency/ Therapist _____

___ Speech and Language Therapy
Agency/ Therapist _____

___ Physical Therapy
Agency/ Therapist _____

Developmental History

Please put approximate ages obtained next to the developmental milestones obtained below.

Example: Rolled over-3 months

rolled over	_____	said first word	_____
held a toy	_____	used sentences (3-4 words)	_____
sat alone	_____	fed self using a spoon	_____
crawled	_____	removed clothing	_____
stood alone	_____	bladder control	_____
walked	_____	bowel control	_____

Describe your child's behavior (i.e., quiet, restless, active, affectionate): _____

Does your child have any unusual fears, habits or routines? If yes, please describe _____

Does your child like routines and have a need for sameness? If yes, please describe _____

Sleep Habits

Does your child sleep through the night? ___yes ___no

Please check all that apply and make comments as necessary

- ___ difficulty falling asleep on his/her own
- ___ difficulty staying asleep
- ___ difficulty with naps
- ___ difficulty going back to sleep once awake

Comments:

Concerns

Please think about what areas you are concerned about. Check any that apply and make comments as necessary. Be specific if possible.

Fine Motor, Visual Motor, and Coordination Skills –Please check off any area that is an age appropriate concern. Please add comments if concern is not mentioned.

Is your child: ___ Right handed ___ Left handed ___ Uses both hands about the same

- paper pencil skills: ex – coloring, tracing, drawing, writing name
- handwriting difficulties
- holding a pencil or crayon
- cutting with scissors
- small motor activities such as stringing beads
- building with blocks or legos
- using two hands when participating in activities
- crossing midline
- pedaling a tricycle or bicycle
- pumping self on a swing
- difficulties with mastering: jumping, hopping, skipping

Comments: _____

Visual Processing Skills: Please check off any area that is an age appropriate concern.
Please add comments if concern is not mentioned.

- reversals of letters and /or numbers
- difficulties with drawing a person
- holds objects abnormally close to the face during small motor tasks
- difficulties with completing puzzles (form board, non interlocking, and jig saw)
- has difficulties finding things in competing backgrounds (toy on a shelf, shoes in room)
- becomes easily distracted by visual stimulation
- has difficulties with discrimination shapes, colors, letters, numbers
- avoids or has difficulties with eye contact
- has difficulties with following an object with his/her eyes
- difficulties with copying from the board at school

Comments: _____

Sensory Processing Skills: Please check off any area that is an age appropriate concern.
Please add comments if concern is not mentioned.

Movement:

- enjoys swinging for long periods of time
- enjoys spinning and getting dizzy
- avoids swings
- hesitates climbing on equipment at a playground or jungle gym
- enjoys and can't get enough climbing on equipment at a playground or jungle gym
- has poor balance
- walks on toes
- jumps on beds and other surfaces
- becomes carsick easily
- dislikes elevator or escalators

- ___ seems fearful of catching a ball
- ___ seems overly active

Comments: _____

Multisensory Processing:

- ___ crashes into things on purpose
- ___ bumps into things by accident
- ___ clumsy and falls a lot
- ___ seems accident prone
- ___ takes excessive risks during play without regards to personal safety
- ___ seeks out rough play and play wrestling
- ___ avoids rough play
- ___ tires easily during activities
- ___ seems to have weak muscles
- ___ takes a long time to do motor tasks
- ___ craves being held and cuddles
- ___ avoids being cuddled

Comments: _____

Tactile:

- ___ negative reactions to touch or texture
- ___ problems with certain types of clothing
- ___ becomes irritated by tags in clothes
- ___ complains if socks aren't on correctly
- ___ dislikes haircutting, shampooing, fingernail and toe nail cutting
- ___ does not like dirty hands by food, paint, glue, markers

Comments: _____

The following pertain to self help skills.

Feeding Please check off any area that is an age appropriate concern. Please add comments if concern is not mentioned.

Does or did your child have any difficulties with breastfeeding or bottle feeding? ___yes ___no
If yes, please comment: _____

Does or did your child have difficulties with transitioning to solid foods ? ___yes ___no
If yes, please comment: _____

Does your child eat a variety of foods? ___yes ___no

List of preferred foods: _____

Strong food preference(s) yes no

Strong food dislikes yes no

If yes, check the tastes that your child won't eat:

sweet salty sour spicy bland

Strong texture preference yes no

Strong texture dislike yes no

If yes, check the textures that your child won't eat:

crunchy smooth hard soft

Does your child mouth nonfood items or toys? yes no if yes, what kind of items? _____

Does your child feed him/herself? (check all that apply)

finger foods with a fork with a sippy cup

with a spoon with an open cup with a straw

Is your child a messy eater? _____

Comments: _____

Play and Social Skills Please check off any area that is an age appropriate concern. Please add comments if concern is not mentioned.

- | | |
|---|--|
| <input type="checkbox"/> interactive play with peers | <input type="checkbox"/> plays with toys properly |
| <input type="checkbox"/> plays with toys for a period of time | <input type="checkbox"/> frequently puts toys in mouth |
| <input type="checkbox"/> plays with other children | <input type="checkbox"/> prefers play with adults |
| <input type="checkbox"/> prefers playground activities | <input type="checkbox"/> prefers table top activities |
| <input type="checkbox"/> pretend play with dolls, cars, etc | <input type="checkbox"/> has difficulties adapting to change |

What are your child's have a favorite toys? _____

What activities is your child least interested in? _____

Comments: _____

Dressing Please check off any area that is an age appropriate concern. Please add comments if concern is not mentioned.

Does your child dress and undress independently yes no
fasten buttons fasten snaps fasten zippers
tie shoes fasten Velcro

Comments: _____

Grooming Please check off any area that is an age appropriate concern. Please add comments if concern is not mentioned.

wash hands toilet trained (bladder/bowel/both)
brush hair brush teeth

Comments: _____

Communication Please check off any area that is an age appropriate concern. Please add comments if concern is not mentioned.

How does your child communicate/or get your attention? (check all that apply)

pointing gestures sounds
single words short phrases

Does your child follow directions? Yes No

How does you child express frustration? _____

How often does your child get frustrated? _____

Comments: _____

Daycare/Preschool/ School

Where does your child attend Daycare/ Preschool/ School? _____

How many days per week?_____ A.M. P.M. Full day

Hours of child's school day:_____ Grade:_____

Has the teacher expressed concerns? Yes No If yes, please check which apply.

Handwriting Cutting Ability to read Ability to spell
 Ability to complete math problems Ability to keep up with classroom work
 Difficulty paying attention Ability to sit still Difficulty following directions
 Transitions in the classroom Sensory concerns

Do you help your child with schoolwork and homework? ___ Often ___ Sometimes ___
Never

Does your child write in: ___ Print ___ Cursive ___ Both ___ Uses a computer to type

Extracurricular Activities

Please check all that apply:

___ swimming ___ basketball ___ soccer ___ football ___ choir ___ dance
___ gymnastics ___ baseball ___ softball ___ hockey ___ martial arts
___ boy/girl scouts ___ therapeutic horsemanship ___ piano ___ violin
___ religious school ___ other: _____

Thank you very much for providing this information which will be helpful in evaluating your child.

You can complete this form in various ways:

- 1. Go to the website to complete (preferred) stjohnspedstherapy.com
Click on OT department/forms/sensory questionnaire. Please fax or mail back before your appointment.
Mail to:
St John's Child Development Center
641 N. New Ballas Rd
St. Louis, MO 63141
Fax: (314) 872-3345
Phone: (314) 872-3345**
- 2. We can mail the questionnaire to you. Please complete and send back before your appointment so the therapist has time to review.**
- 3. If you cannot do any of the above, please come to your appointment 15 minutes early to complete the questionnaire.**