FUNctionabilities Occupational Therapy

Pre-Exam Questionnaire Ages 3-5.11

In order to evaluate your child's condition fully, please be as accurate as possible. Thank you.

Child's Name _____ Date of Birth _____

Birth and Medical History

1. Were there any difficulties or complications during pregnancy, at, or shortly after birth? ☐ Yes (Please explain below) ☐ No

2. Describe your child's behavior before age 1 **(check all that apply):** ☐Easy ☐Difficult ☐Active ☐Enjoyed cuddling ☐Quiet ☐Sociable ☐Cried frequently ☐Tense when held ☐Poor sleep patterns ☐Head banging

3. List all medical conditions your child has or that you suspect your child has - if your child has a history of seizures, include the actions you want us to take if your child has a seizure:

4. Is your child taking any medication(s)? ☐ Yes (Please list medication and what it is treating) ☐ No

5. List all past surgeries and major injuries with dates:

6. Please list any allergies that your child has (include recommended actions to allergens if applicable):

Developmental History

Please mark the following based on your child's behavior from 3 – 4 years old:
☐Took turns in games ☐Showed concern for sad friend ☐Understood mine/his/hers ☐Followed 2-3 step instructions
☐Understood**:** in, on, under ☐Named a friend ☐Used toys with buttons/moving parts ☐Copied circle with crayon
☐Screwed/unscrewed lids; turned door handles ☐Climbed well ☐Completed stairs, one foot per step

Please mark the following based on your child's behavior from 4+ years old:
☐Enjoys new things ☐Prefers playing with kids ☐Talks about interests ☐Tells stories ☐Names colors/numbers
☐Draws person with 6+ body parts ☐Uses scissors ☐Catches bounced ball ☐Pours with supervision, uses a fork/spoon
☐Wants to be like friends ☐Likes to sing, dance, & act ☐Counts 10+ items ☐Copies a triangle ☐Can do somersaults

1. Does your child like to run? ☐ Yes ☐ No Does your child pedal a tricycle ☐ Yes ☐ No Bike? ☐ Yes ☐ No

2. Does your child frequently bump into things, fall, or have difficulty learning new motor skills? ☐ Yes ☐ No

Therapy / Educational History

1. Please list all past and current therapy, medical, and psychological services/evaluations:

2. Does your child comprehend directions as well as other children? ☐ Yes ☐ No

3. Your child's level of intellegence compared to other children? ☐ Below average ☐ Average ☐ Above average

4. What grade level is your child in: ☐ Reading ☐ Spelling ☐ Math ☐ Writing

5. If your child attends preschool/daycare, do they report any of the following: **(Check all that apply)** ☐Often out of seat ☐Doesn't wait for turn ☐Poor sharing ☐Difficulty in groups ☐Poor attention ☐Difficulty with free play ☐Difficulty with field trips/assemblies/movies

Occupational History

1. What activities does your child love doing the most?

2. What are your child's greatest accomplishments?

3. What does your child dislike the most?

4. Does your child have difficulty with daily routines? Please describe:

5. Describe your child now: **(Check all that apply):** ☐Mostly quiet ☐Talks constantly ☐Overly active ☐Tires easily ☐Impulsive ☐Resists changes ☐Usually happy ☐Frequent temper tantrums ☐Clumsy ☐Poor attention ☐Nervous habits/ticks (e.g . _____) ☐Soils pants or bed (How often/per week?_____) ☐Unusual fears (e.g. _____) ☐Poor listener ☐Poor table manners ☐Wears shoes out quickly ☐Has excessive accidents/injuries ☐Doesn't learn from experience ☐Excessive reaction to noise

1. What are your primary concerns? (Describe below)

2. Are your family's everyday activities affected? ☐ Yes (Describe below) ☐ No

3. When did it start? _____ Is it getting: ☐ Worse ☐ Better ☐ Staying the same

4. How often do you experience these problems with your child?

5. On the scale below <u>circle</u> your <u>worst</u> level for the child's problem(s) in the past couple of days:

Mild *Moderate* *Severe*
0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10

Patient Name:_____ Parent Signature:_____Date _____