FUNctionabilities Occupational Therapy

Pre-Exam Questionnaire Ages 6+

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 as a baby **(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:
Were motor and self-care milestones met on time? ☐ Yes ☐ No ☐ Not sure

Please mark the following based on your child's behavior at 1-2 years old:
☐Repeated actions for attention ☐Followed simple requests ☐Used gestures (shook head 'no', waved) ☐Turned thick pages ☐Pulled to stand ☐Walked holding furniture ☐Helped with dressing ☐Took turns in games

Please mark the following based on your child's from 3-5:
☐Followed directions ☐Built tower of 10+ blocks ☐Ran easily without falls ☐Counted 10+ items ☐Liked to sing/dance ☐Drew person with 6+ body parts ☐Balanced on one foot 10+ seconds ☐Could do somersaults ☐Uses a fork and spoon

1. Does your child prefer one hand over the other? ☐ Yes ☐ No ☐ Right ☐ Left

2. Does your child like to run? ☐ Yes ☐ No Does your child ride a bicycle (not a scooter)? ☐ Yes ☐ No

3. Can your child dress his/herself including all clothing fasteners (buttons, zippers, snaps, tie shoes? ☐ Yes ☐ No

4. Does your child frequently bump into things, trip, or have difficulty learning new motor skills? ☐ Yes (Explain below) ☐ 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. Has your child repeated a grade? ☐ Yes ☐ No Current Placement: ☐ Regular class ☐ Special class / IEP

4. Is your child on grade level in: ☐ Reading ☐ Spelling ☐ Math ☐ Writing

5. Teacher complaints: **(Check all that apply)** ☐Often out of seat ☐Doesn't wait for turn ☐Poor group work ☐Poor attention ☐Difficulty with independent work ☐Difficulty with field trips/assemblies/discussions

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 at present: **(Please check all)** ☐Quiet ☐Overly active ☐Tires easily ☐Frequent temper tantrums ☐Impulsive ☐Resists change ☐Fights frequently ☐Usually happy ☐Talks constantly ☐Poor separation from caregivers ☐Nervous habits/ticks (e.g . _____) ☐Falls often/clumsy ☐Wets/soils pants (How often?_____) ☐Poor attention ☐Unusual fears (e.g. _____) ☐Poor attention ☐Interrupts often ☐Sloppy table manners ☐**S**hoes wear out quickly ☐Takes **e**xcessive risks ☐Difficulty learning from experience ☐Poor memory

Other:

1. What are your primary concerns?

2. How often are your family's daily activities affected?

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

4. Has your child had these problems before? ☐ Yes ☐ No

5. On the scale below circle your worst 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 _____