#

# Occupational Therapy Pre-Exam Questionnaire

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

Child’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Developmental History

1. Were motor and self care milestones met on time? **[ ]**  Yes **[ ]**  No **[ ]**  Not sure

Age met milestone: Rolled \_\_\_\_, Crawled \_\_\_\_, Walked \_\_\_\_, Jumped \_\_\_\_Reached \_\_\_\_, Finger feed \_\_\_\_,

Eat with spoon\_\_\_\_\_, Drink from open cup\_\_\_\_\_, Dress self \_\_\_\_\_\_\_\_, Clothing fasteners\_\_\_\_\_\_\_\_

Draw circle\_\_\_\_\_\_Cut with scissors\_\_\_\_\_\_Use knife for cutting\_\_\_\_, Toilet trained \_\_\_\_\_\_\_\_\_

2. Does your child prefer one hand over the other? **[ ]**  Yes **[ ]**  No Right or Left?

3. Do you consider your child clumsy, showing poor control of body movements or having difficulty learning new

 motor skills? **[ ]**  Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **[ ]**  No

Occupational History

 1. What are your child’s favorite activities and things he/she loves doing the most ?

2. What does your child dislike the most?

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

4. Describe your child at present: (circle all that apply):

Mostly quiet / overly active / tires easily / talks constantly / too impulsive / restless / stubborn / resistant to changes / fights frequently / usually happy / frequent temper tantrums / clumsy / difficulty separating from primary caretaker / nervous habits or ticks / falls often / wets bed / wets or soils pants/ poor attention span / unusual fears / rocks self frequently / engages in activity a reasonable length of time / interrupts frequently / more active that siblings or other children same age / a “different child” / sloppy table manners / does not listen / sudden outbursts / excessive number of accidents / does not learn from experience / poor memory /

fails to react to loud noises / over reacts to touch / excessive reaction to noise / gets stuck / self stimulation / compulsive rituals / motor or vocal tics / odd postures

5. What are your primary concerns and the primary problems? Are you concerned about your child’s judgement for safety?

 Please describe:

 6. On the scale below circle your level of concern for your child:

##

## Mild Moderate Severe

0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10

 7. How often do you experience these problems with your child? Constantly Daily Weekly

 8. Are any of your family’s everyday activities affected? **[ ]**  Yes **[ ]**  No

 - If yes, describe how.

 9. What do you think has caused this problem?

 10. Approximately when did it start?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is it getting worse, better, or staying the same?

 11. Has your child had these problems before? **[ ]**  Yes **[ ]**  No