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# 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