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