Sensational Achievements

Aubrey Schmalle, OTR/L, Executive Director
p: 203.200.7256 f: 646.626.7586
aubrey@sensational-achievements.com
1011 High Ridge Road, Suite 300 Stamford, CT 06905
www.sensational-achievements.com

Identifying/Background Information

Date:_____

Client Name:_____Date of Birth:_____ Age:_____
Address:_____
City:_____State:_____Zip Code:_____
Cell:_____Email:_____
Home Phone Number:_____
Parents' Names (if live at home):_____
Mom's Cell:_____ Dad's Cell:_____
Mom's Email:_____ Dad's email:_____
Primary Contact:_____ Relationship:_____
Emergency Contact:_____ Relationship:_____
Emergency Contact Phone Number:_____
Referred By:_____

School Information if applicable (contact information is optional)
School Attending: _____Grade:_____
Teacher: _____Email:_____
Phone:_____

Medical Contact Information:
Primary Physician:_____ Phone:_____

Do you have a prescription for an OT services? (recommended if submitting to insurance) YES NO

Do you have specific diagnosis codes from a psychologist or neurologist supporting the need for services? If yes, please bring a prescription with them listed to the first session.

Have you received any therapy services previously (counseling, tutoring, speech, ABA, PT, OT, oral motor)? When, where and for how long?

_____
_____
_____
_____

What are your primary concerns which brought you to possibly seek out therapy?
Home:_____
_____
School/
Work:_____
_____
Social-Emotional/Peer Relationships:_____
_____

Sensational Achievements

Aubrey Schmalle, OTR/L, Executive Director
p: 203.200.7256 f: 646.626.7586
aubrey@sensational-achievements.com
1011 High Ridge Road, Suite 300 Stamford, CT 06905
www.sensational-achievements.com

Relevant Medical and Developmental History

Mother's Pregnancy/Birth History:
Complications, illness, or major stressors during pregnancy? Y/N
(Describe)_____
_____
Complications during labor and delivery? Y/N
(Describe)_____
_____
Premature/Postmature/Full-Term (Circle One)
Birth Order:_____ Birth Weight:_____
Breast Fed? Y/N How Long? _____ Strong suck? Y/N Spit up frequently? Y/N
Feeding or sleeping problems as an infant? Y/N
(Describe)_____
General Disposition: Irritable/ Happy/ Quiet (circle one) Did baby arch back and head when upset? Y/N

Developmental Milestones (Please provide the approximate ages when these occurred if known)
Rolled Over_____ Sat_____ Belly Crawled_____ Crawled_____ Cruised_____ Walked_____
Said first words_____ Talked (2-3 word sentences) _____
Toilet Trained: Bowel_____ Bladder_____
Undressed Self (pullover garments) _____ Dressed Self (pullover garments) _____
Managed snaps, buttons, zippers _____ Tied Shoes_____ Started Preschool_____

Medical History:
Ear infections as a child? How many per year?_____
Reflux as an infant? Y/N _____
Frequent Colds or last longer than expected? Y/N_____
Allergies or food sensitivities?_____
_____
Seizures? Y/N _____ Significant Injuries Y/N _____
Hospitalizations Y/N_____
Medications? Y/N List:_____
Glasses? Y/N Reason:_____
Family History of relevant physical or mental illness:
_____
Ages and Sex of Siblings: _____
_____

Types of therapy you are interested in:

☒ Sensory integration-based occupational therapy
☒ Home-Based listening programs
☒ Referral to Tomatis Listening Program
☒ Handwriting and fine motor skills
☒ Nutritional Interventions
☒ Consulation and Home Programming
☒ Visually enhanced occupational therapy (for people with ocularmotor deficits)

Sensational Achievements

Aubrey Schmalle, OTR/L, Executive Director
p: 203.200.7256 f: 646.626.7586
aubrey@sensational-achievements.com
1011 High Ridge Road, Suite 300 Stamford, CT 06905
www.sensational-achievements.com

Occupational Therapy Adolescent/Adult Questionnaire

The following questions are designed to help you consider areas of need in your daily life that may be impacted by deficits in planning/sequencing, attention, sensory processing, motor skills, vision deficits, and delays in fine motor and handwriting skills. Please answer them to the best of your ability in order to develop an appropriate treatment plan. Please also note if items were difficult for you as a child but seem to have resolved as you have gotten older

Activities of Daily Living:

Circle the answer that BEST describes you. Circle H is this was difficult for you as a child.
(N=Never O=Occasionally F=Frequently A=Always)

Dressing:

N O F A H Prefer specific textures of clothing _____
N O F A H Resist changing clothes
N O F A H Difficulty shifting between seasonal clothing
N O F A H Avoid wearing socks/shoes
N O F A H Hate to be barefoot
N O F A H Hyperaware of tags, seams on socks, "Itchy" clothes, tight clothing (belts,ties)
N O F A H Avoid/Love wearing hats (circle one)
N O F A H Lean on objects or sit down to balance while getting dressed
N O F A H Difficulty managing fasteners/tying laces
N O F A H Cannot wear stiff clothes, need to wash or soak them in fabric softener first
Other concerns:_____

Bathing/Water-Based Activities

N O F A H Avoid splashing water/water parks/waves at the beach
N O F A H Resist head tipping to wash hair
N O F A H Prefer specific water temperature/sensitive to temperature change
N O F A H Difficulty learning how to swim or performing swimming strokes
N O F A H Disoriented underwater, especially if you can't see or are doing a flip
Other concerns: _____

Sleeping

N O F A H Difficulty falling asleep or staying asleep
N O F A H Frequent waking during the night
N O F A H Seem to need less sleep than others
N O F A H Seem to need more sleep than others
N O F A H Need white noise/music to fall asleep
N O F A H Difficulty falling asleep if lights are on nearby or it is not completely dark
N O F A H Need to sleep with multiple/heavy blankets on top of you

Grooming/Toothbrushing/Toileting

N O F A H Strongly prefer a particular type of toothbrush
N O F A H Strong preference for flavor of toothpaste or mouthwash
N O F A H Avoidance of dental work and check-ups
N O F A H Anxiety around personal toileting schedule

N O F A H Anxiety using public restrooms or toilets outside your home
N O F A H Overly conscious of personal cleanliness/appearance
N O F A H Infrequent attention to overall personal hygiene/appearance
Other concerns:_____

Eating
N O F A H Limit self to particular food textures (ex: crunchy, soft, avoids mixed textures like fruit yogurt)
N O F A H Avoid foods that are hard to chew (ex: meats)
N O F A H Prefer foods with strong flavors or is spicy
N O F A H Prefer bland foods and mild tastes
N O F A H Prefer crunchy foods (chips, popcorn, nuts, pretzels)
N O F A H Avoid messy food or don't like to get messy in general
N O F A H Strong preference for certain temperatures of food: _____
N O F A H Bite tongue often by accident
N O F A H Have difficulty managing utensils without spilling
N O F A H Have difficulty opening lids/containers
N O F A H Spill frequently
N O F A H Prefer water bottles that you can bite over hard plastic
N O F A H Stuff food in your mouth or are a fast eater
N O F A H Take a long time to chew or are a slow eater
N O F A H Difficulty having a conversation and eating at the same time
N O F A H Mood highly influenced by eating pattern (ex: irritable if haven't eaten for 3 hours)
N O F A H Sensitive to sugar or caffeine – Notable feelings of being hyper or "jittery"
Other concerns: _____

Sounds/Smells in the Environment
N O F A H Overreact to sirens, sudden noises, vacuums, barking dogs
N O F A H Talk too loud or soft
N O F A H Hyperaware of sounds others don't notice (clock ticking, fridge running, computer hum)
N O F A H Difficulty identifying dangerous smells (gas, burning, cleaning agents)
N O F A H Hypersensitive to smells, become nauseous from odors
N O F A H Frequently use air fresheners, candles, and sprays to mask odors
N O F A H Use smells to decide if you like something or not

Activity Level and safety
N O F A H Thrill Seeker
N O F A H Excessive risk taking without consideration/awareness of consequences
N O F A H Overly cautious, spend a lot of time thinking before initiating a task so you don't get hurt or avoid it all together
N O F A H Trip or are clumsy/accident prone
N O F A H Runs into objects or people
N O F A H Misjudge how close you are to objects in the environment
N O F A H Engage in extreme sports
N O F A H Prefer solitary sports over group sports
N O F A H Avoid sports, Prefer sedentary activities List:_____
N O F A H Very musical/Play an instrument Type: _____
N O F A H Strong preference for certain types of music List: _____
N O F A H Overly sensitive to pain compared to others
N O F A H Not aware when you get hurt but notice afterward with bleeding/bruising
N O F A H Dislike going to the beach, sand blowing or sticking to you
Other concerns:_____
_____

Learning/Approach to Tasks
Have an established hand dominance Y/N Right/Left (circle one)

N O F A H Take a long time to learn new skills/concepts
N O F A H Difficulty learning multi-step motor tasks (tying a tie, dancing, karate sequences)
N O F A H Avoid writing and drawing – prefer computer
N O F A H Have poor/illegible handwriting
N O F A H Have difficulty with copying/note taking
N O F A H Difficulty lining up numbers for math problems
N O F A H Have difficulty staying seated for long periods unless watching TV/On the computer
N O F A H Spend hours on fantasy and video games/activities
N O F A H Hum or vocalize when concentrating
N O F A H Have difficulty paying attention and following complex verbal directions
N O F A H Have difficulty following a group discussion
N O F A H Disorganized with regard to assignment or project completion
N O F A H Have trouble meeting deadlines and staying on task
N O F A H Difficulty making decisions and following through
N O F A H Need directions repeated or have difficulty understanding what others say, especially in a busy environment
N O F A H Easily distracted by noise or movement in the room
N O F A H Have difficulty transitioning: Ex: takes a long time to get out of the house in the morning
N O F A H Become engrossed in a task to the point of blocking out everything else
N O F A H Lethargic, hard to get going, unmotivated
N O F A H On the go, trouble sitting down to focus and start a project
N O F A H Prefer to work alone. Difficulty working on group projects
N O F A H Prefer repetitive, predictable work
N O F A H Prefer physical work over sitting at a desk
N O F A H Prefer work schedule/task to be driven by the manager – Like structure
N O F A H Prefer work tasks to be open-ended with room for error/improvement
N O F A H Difficulty locating items in cupboards, drawers, grocery store, closet
N O F A H Get lost easily in stores, malls, new buildings, hiking
N O F A H Difficulty following written directions or diagrams
N O F A H Talk self through tasks

Driving:
N O F A H Difficulty following and interpreting traffic signs
N O F A H Difficulty locating places on a map and using maps to orient to streets/places
N O F A H Difficulty judging distances when driving to park, change lanes, or get close to a curb
N O F A H Difficulty merging with traffic and changing speeds between local roads and highways
Other:_____

Body Awareness/Balance
N O F A H Use excessive force when manipulating objects, don't know your own strength
N O F A H Frequently bump into things
N O F A H Difficulty identifying objects by touch (feeling in your pocket or purse for items)
N O F A H Difficulty walking on uneven surfaces
N O F A H Easily fatigued with physical tasks
N O F A H Frequently drop items
N O F A H Lose balance frequently

N O F A H Confuse right and left
N O F A H History of toe walking

Vision and Visual-Vestibular Integration:
Have you had a vision screening in the last year? Y/N Results: _____
Have your ever been evaluated by a developmental optometrist for ocularmotor deficits? Y/N (Note: this is different from a vision screen that focuses on how clearly you can see)_____
Does you have diagnosed vision deficits?_____
When did you receive this diagnosis?_____
Has any intervention been performed? (ex: glasses, therapy, patching, surgery)_____
_____

N O F A H Poor eye contact
N O F A H Difficulty looking directly at people when they are talking
N O F A H Blink excessively after engaging in visual activities (ball sports, tabletop tasks)
N O F A H Eyes water or feel the need to engage in eye rubbing with tabletop vision tasks (ex: computer work, reading)
N O F A H Have difficulty scanning a page for relevant information
N O F A H Close or cover one eye or lean to one side while drawing/writing
N O F A H Take breaks, walk around, or stare into the distance during writing/drawing tasks
N O F A H Poor reading comprehension or skip words/lines while reading
N O F A H Lines run together when copying words/pictures
N O F A H Act of reading is so difficult, it is difficult to absorb the content
N O F A H Guess at words or skim briefly for main content versus reading
N O F A H Reverse words/Letters
N O F A H Poor posture while reading/writing
N O F A H Turn paper instead of drawing lines in different directions
N O F A H See double at times
N O F A H Eyes feel hot or itchy at times
N O F A H Bothered by bright lights
N O F A H Turn away from balls or other objects coming toward him/her
N O F A H Can catch/hit a target in standing but not if moving (ex: run to kick a ball)
N O F A H Get anxious that you will bump into something when riding on moving surfaces (ex: roller coasters, bikes)
N O F A H Like to be in control of movement (ex: driver not the passenger)
N O F A H Perceive yourself as being higher off the ground than you really are when standing on raised surfaces
N O F A H Become anxious in glass elevators
N O F A H Become anxious in all kinds of elevators
N O F A H Avoid amusement park rides that spin or go upside down
N O F A H Strong preference for “fast” rides, going fast, spinning, etc
N O F A H Have trouble looking at objects while moving (ex: focusing on a ball/target while running)
N O F A H Avoid tipping head backward/upside down
N O F A H Prefer being upright (versus laying down, rolling, flipping)
N O F A H Becomes car dick: Does it improve/get worse if you are looking out the window? (circle one)
N O F A H Rock or sway frequently in standing

Relationships
N O F A H Dislike/Distressed by others touching you/cuddling on the couch
N O F A H Bothered by light touch – someone rubbing your hand, face, back
N O F A H Excessively ticklish
N O F A H Startle with unexpected touch, someone approaching from behind

N O F A H Love firm pressure, cuddling, hugging
N O F A H Like to touch everything
N O F A H Easily irritated by group members/coworkers when discussing a problem/project
N O F A H Poor frustration tolerance when others don't act the way you would like them to
N O F A H Avoid crowds (shopping, amusement parks, sporting events)
N O F A H Become overwhelmed/overstimulated with lots of people in the house or in busy places
N O F A H A "Sore" loser
N O F A H Difficulty with authority figures
N O F A H Difficulty reading social cues and nonverbal language
N O F A H Trouble relating to others/forming deep friendships
N O F A H Trouble socializing in a casual setting (bar, party, etc)
N O F A H Difficulty seeking out and maintaining relationships

Emotional Traits/Coping Behaviors

N O F A H Frequent fidgeting with items in your pocket, doodling, or always need to hold something
N O F A H Frequently chewing the ends of pens/pencils
N O F A H Frequent leg shaking in sitting position
N O F A H Bite nails/fingers excessively
N O F A H Bite lips or inside of cheeks
N O F A H Crack knuckles
N O F A H Smoke cigarettes
N O F A H Frequently anxious
Y N History of substance abuse, current use, or experimentation (Circle one)
N O F A H Rigid/Controlling
N O F A H People describe you as stubborn, defiant, or uncooperative
N O F A H Cry easily, very emotional/sensitive
N O F A H Impatient/Impulsive
N O F A H Strong feelings of anger/rage
N O F A H Easily frustrated
N O F A H Like to know what to expect/prefer sameness
N O F A H Have panic or anxiety attacks
N O F A H Plagued by fears/phobias
N O F A H OCD-Type behaviors: don't like food to touch, obsessively clean, cannot do, need to do, have to have…
N O F A H Hate surprises
N O F A H Breathe too fast/slow for a particular situation
N O F A H Heart rate constantly too fast or slow

Thank you for taking the time to fill out this questionnaire. Please contact your occupational therapy service provider with any additional questions/thoughts.