Sensational Achievements

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Identifying/Background Information

Date:_____

Client Name:_____Date of Birth:_____ Age:_____
Address:_____
City:_____State:_____Zip Code:_____
Parents' Names:_____
Home Phone Number:_____
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 (contact information is optional)
School Attending: _____Grade:_____
Teacher: _____Email:_____
Phone:_____

Medical Contact Information:
Primary Pediatrician:_____ Phone:_____

Do you have a prescription for an OT and/or Speech evaluation and/or services? (recommended if submitting to insurance) YES NO

Does your pediatrician have specific diagnosis codes supporting the need for services? If yes, please bring a prescription with them listed to the first session.
Is your child receiving or has your child received any therapy services previously (speech, ABA, PT, OT, oral motor)? When, where and for how long?

_____
_____
_____
_____

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

Developmental History

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)
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? How many per year?_____
Reflux as an infant? Y/N _____
Frequent Colds or last longer than expected? Y/N_____
Allergies? _____
Seizures? Y/N _____ 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
- ☐ Picky Eating/Feeding/Oral Motor Groups
- ☐ Nutritional Interventions
- ☐ Co-treatments with speech or behavioral therapy
- ☐ Visually enhanced occupational therapy (for children with vision deficits)
- ☐ Other:_____

Occupational Therapy Questionnaire

The following questions are designed to help you consider areas of need in your child's 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 for your child.

Activities of Daily Living:

Circle the answer that BEST describes your child
(N=Never O=Occasionally F=Frequently A=Always)

Dressing Skills:

N O F A Prefers specific textures of clothing _____
N O F A Resists changing clothes
N O F A Has difficulty shifting between short and long sleeves
N O F A Avoids wearing socks/shoes
N O F A Hyperaware of tags, seams on socks, "Itchy" clothes
N O F A Avoids/Loves wearing Hats (circle one)
N O F A Needs help to balance while getting dressed (leans on people/objects)
N O F A Has trouble figuring out how to put on clothing
N O F A Requests help with dressing
N O F A Attempts to dress self independently
N O F A Needs to be supervised throughout dressing routine to stay on task
N O F A Needs help with buttons/snaps/zippers
Other concerns:_____

Bathing

N O F A Avoids splashing water
N O F A Resists head tipping to wash hair
N O F A Washes body with supervision (3.5+ years)
N O F A Prefers showers/ Baths
N O F A Avoids washing hands/face
N O F A Needs supervision to complete bathing routine (6+ years)
Other concerns: _____

Grooming/Toothbrushing/Toileting

N O F A Swallows instead of spitting toothpaste
N O F A Needs assistance to brush all areas of mouth
N O F A Needs physical assistance to complete toothbrushing routine (after 4 years old - put on toothpaste, wet brush, brush teeth, rinse, etc)
N O F A Blows nose with tissue
N O F A Requests tissue as needed
N O F A Avoids/Resists having nose wiped
N O F A Completes toileting routine independently
N O F A Needs prompts for each step of toileting routine
N O F A Needs assistance to manage clothing during toileting routine
N O F A Needs assistance to wipe after bowel movements
N O F A Initiates/Verbalizes need to go to the bathroom
N O F A Has accidents after fully potty trained
N O F A Has issues with constipation or "holding" urine
Other concerns:_____

Eating

N O F A Limits self to particular food textures (ex: crunchy, soft, avoids mixed textures like fruit yogurt)
N O F A Drinks from a cup without spilling
N O F A Drools while eating or playing
N O F A Avoids foods that are hard to chew (ex: meats)
N O F A Has difficulty managing utensils without spilling
N O F A Has difficulty opening lids/containers
N O F A Spills frequently/Is a messy eater
N O F A Does not seem aware of food on face
N O F A Needs reminders to use napkins
N O F A Bites straws instead of sucking appropriately
N O F A Stuffs food in his/her mouth
N O F A Needs encouragement to fully chew foods or spits food out
Other concerns: _____

Safety Awareness
N O F A Seems unaware of safety during play
N O F A Needs constant supervision to avoid unsafe play
N O F A Trips or is clumsy
N O F A Runs into objects or people – Doesn't seem to look where he/she is going
N O F A Misjudges how close he/she is to objects in the environment
N O F A Runs into the street or parking areas if hand is not held
Other concerns:_____
_____

Educational Concerns:

Has an established hand dominance Y/N Right/Left (circle one)

N O F A Takes a long time to learn new skills
N O F A Avoids writing, drawing or fine motor tasks
N O F A Has difficulty using two hands together to cut or stabilize paper
N O F A Has poor/illegible handwriting
N O F A Has poor spacing or sizing of letters/words/sentences
N O F A Has difficulty with copying from the board
N O F A Writing/Drawing skills are below what is expected for child's age
N O F A Has difficulty staying seated or is very fidgety
N O F A Has difficulty paying attention and following directions
N O F A Has difficulty following a group discussion
N O F A Is disorganized/needs supervision to complete classroom routines
N O F A Has trouble completing work in a timely manner or needs frequent breaks
N O F A Needs directions repeated. Does not seem to hear what the teacher says
N O F A Easily distracted by noise or movement in the room
N O F A Has difficulty transitioning to/from playground, lunch, or during drop off/pick up
N O F A Has trouble sitting down to complete homework
N O F A Frequently plays alone during free play
N O F A Has difficulty participating in group activities _____
N O F A Does not join in gross motor play on the playground
N O F A Limited participation in gym class
N O F A Has meltdowns or seems exhausted after school
Other concerns:_____

Vision and Visual-Vestibular Integration:
This clinic is currently trying to collect data on visual and visual-vestibular related deficits that impact participation at home, school, and in play with peers. It is this clinic's belief that better

diagnosis of these issues will allow for advances in treatment approaches and a better understanding of how the visual and vestibular (balance and movement) system develop and function. Some of these questions pertain only to children of reading age (first grade). Please answer these questions to the best of your ability.

Has your child had a vision screening in the last year? Y/N Results: _____

Has your child 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 a child can see)_____
Does your child have diagnosed vision deficits?_____
When did your child receive this diagnosis?_____
Has any intervention been performed? (ex: glasses, therapy, patching, surgery)_____
_____

N O F A	Poor eye contact
N O F A	Child looks toward you but does not seem to look AT you when talking/listening
N O F A	Blinks excessively after engaging in visual activities (ball sports, tabletop tasks)
N O F A	Eyes water or child engages in eye rubbing with tabletop vision tasks (ex: homework, puzzles)
N O F A	Has difficulty scanning for hidden objects on a page
N O F A	Closes or covers one eye or leans to one side while drawing/writing
N O F A	Takes breaks, walks around, or stares into the distance during writing/drawing tasks
N O F A	Poor reading comprehension or skips words/lines while reading
N O F A	Child reports that lines run together when copying words/pictures
N O F A	Act of reading is so difficult, child doesn't seem to recall story
N O F A	Guesses at words versus reading them even though child has been taught to read
N O F A	Reverses words/Letters
N O F A	Poor posture while reading/writing
N O F A	Turns paper instead of drawing lines in different directions
N O F A	Reports seeing double at times
N O F A	Child reports eyes feeling hot or itchy at times
N O F A	Bothered by bright lights
N O F A	Turns away from balls or other objects coming toward him/her
N O F A	Can catch/hit a target in standing but not if moving (ex: run to kick a ball)
N O F A	Gets anxious that he/she will bump into something when riding on swings or other moving surfaces
N O F A	Likes to be in control of movement (ex: push himself but not allow himself to be pushed on a swing)
N O F A	Perceives him/herself as being higher off the ground than he/she really is when standing on raised surfaces
N O F A	Becomes anxious in glass elevators
N O F A	Becomes anxious in all kinds of elevators
N O F A	Closes eyes or looks down when swinging or being spun around
N O F A	Has trouble looking at objects while moving (ex: focusing on a ball/target while running)
N O F A	Loves to bounce/Jump but becomes disoriented/fearful with spinning
N O F A	Loves to spin but jumping is limited
N O F A	Looks for opportunities to tip head upside down
N O F A	Avoids tipping head backward/upside down
N O F A	Prefers being upright (versus laying down, rolling, flipping)
N O F A	Does not look at parent/caregiver while being pushed on a swing if caregiver is in front of him/her

N O F A Becomes Car Sick: Does it improve/get worse if he/she is looking out the window? (circle one)

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