AppyTherapy
Occupational Therapy

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BACKGROUND QUESTIONNAIRRE

Thank you for bringing your child to AppyTherapy! This questionnaire is designed to help us understand your child's needs and the best way to meet them.

Child's Full Name _____ DOB _____ Today's Date _____

Who referred you? _____

Reason for Referral _____

Street Address _____

City _____ State _____ Zip _____

School _____ Grade _____

Completed by _____ Relationship to child _____

FAMILY INFORMATION

Parent's Name _____ Parent's Name _____

Occupation _____ Occupation _____

Employer _____ Employer _____

Email _____ Email _____

Home # _____ Home # _____

Cell # _____ Cell # _____

Work # _____ Work # _____

List the names and ages of the children in your family

Name	Age

Do any relatives have learning disabilities, speech problems, ADD or ADHD or emotional problems? ○ Yes ○ No

If yes, please indicate family relationship and describe problems.

_____

_____

Are there any events or situations in the family that may be affecting the child adversely? ○ Yes ○ No

If yes, please explain.

_____

DEVELOPMENTAL INFORMATION

Birth History

Full Term ☐ Premature # of weeks_____

Drug/Alcohol use during pregnancy _____

Complications during pregnancy or delivery _____

Health concerns at birth _____

Early Development

At what approximate ages were the following skills achieved

Sitting Unassisted _____
Crawling _____
Walking _____

First Words _____
Finger Feeding _____
Toilet Trained _____

Is your child able to independently manage:

buttons	○ Yes ○ No	finger foods	○ Yes ○ No
shoelaces	○ Yes ○ No	fork	○ Yes ○ No
snaps	○ Yes ○ No	spoon	○ Yes ○ No
zippers	○ Yes ○ No	knife	○ Yes ○ No
tricycle	○ Yes ○ No	scooter	○ Yes ○ No
bicycle	○ Yes ○ No	pump a swing	○ Yes ○ No

General Health

List any hospital stays or surgeries including approximate ages:

_____

_____

Current or ongoing health concerns

_____

_____

_____

Special tests or screenings_____

Precautions or special medical needs _____

Current medications_____

Current allergies_____

Hearing status _____

History of ear infections ○ Yes ○ No ○ Ear Tubes

SENSORY-MOTOR SKILLS

Indicate whether your child exhibits any of the following behaviors on a regular basis, either currently or in the past.

	Currently	*In the past*
TOUCH		
Avoids playing with "messy" substances (finger paint, glue, etc.)	○	○
Complains that clothing is uncomfortable or bothered by tags on clothing	○	○
Over or under dresses regardless of the weather	○	○
Seems unaware of being touched or bumped	○	○
Overly sensitive to being touched, pulls away from light touch	○	○
Uncomfortable in large group situations (circle time, recess, dismissal)	○	○
Examines objects by putting them in his/her mouth	○	○
Dislike being cuddled or hugged	○	○
Seeks cuddling and hugs from others	○	○
Seeks quantities of jumping and crashing	○	○
Reacts negatively to hair cuts	○	○
Refuses many foods (a picky eater)	○	○
Pinches, bites, or otherwise hurts self	○	○
Seems unaware of bruises or bumps	○	○
Seems overly sensitive to slight bumps or scrapes	○	○
Tends to touch things constantly	○	○
Pushes, hits, or acts aggressively towards other children	○	○
MOVEMENT		
In constant motion, unable to sit still for an activity	○	○
Fearful of going down stairs	○	○
Dislikes amusement park rides, swings, or slides.	○	○
Fearful of heights	○	○
Gets motion sickness (car rides, swings, merry-go-rounds)	○	○
Seeks twirling, spinning, or rocking	○	○
Seeks fast movement experiences	○	○
Hesitates to climb or play on playground equipment	○	○
Dislikes active running games, PE class, or sports	○	○
Poor safety awareness (daredevil, risk-taker)	○	○
Fall or trip often	○	○
AUDITORY		
Overly sensitive to loud or unexpected noises	○	○
Speaks unclearly	○	○
Difficulty following directions	○	○
Easily distracted by sounds that go unnoticed by others	○	○
Trouble following a multi-step (<2 steps) verbal command	○	○
Difficulty listening in a noisy setting (cafeteria, party, recess, classroom)	○	○

	Currently	*In the past*
VISUAL		
Difficulty discriminating colors, shapes, or sizes	○	○
Difficulty completing puzzles; trial and error placement of pieces.	○	○
Reverse words or letters	○	○
Rubs eyes after reading or looking at something for a period of time	○	○
Complains of headaches	○	○
Becomes irritated or fatigued by bright lights	○	○
Becomes easily distracted when there is a variety of visual stimuli present	○	○
Difficulty keeping place when reading	○	○
Difficulty copying from the board or another paper	○	○
GROSS MOTOR		
Weaker than peers or tires easily with physical activity	○	○
Clumsy and awkward in movements	○	○
Avoids participating in sports or physical activities	○	○
Difficulty learning new motor tasks (e.g. riding a two-wheel bicycle, pumping self	○	○
Poor sitting / standing posture	○	○
Appears loose and "floppy"	○	○
FINE MOTOR		
Avoids writing, drawing or coloring	○	○
Poorly established hand dominance	○	○
Breaks pencils more often than usual or presses hard	○	○
Drops things frequently	○	○
Produces faint or shaky lines when writing or drawing	○	○
Avoids playing with small toys (e.g., Lego, puzzles)	○	○
Poor or awkward pencil grip	○	○
SELF-CARE		
Messy eater	○	○
Eats more slowly than others	○	○
Requires help to fall asleep	○	○
SELF-REGULATION		
Fleeting attention; easily distracted	○	○
Over focus on one activity; perseverates on tasks	○	○
Difficulty staying seated to complete tasks (eat a meal, etc.)	○	○
Difficulty calming self effectively when upset or over-excited	○	○
SOCIAL ADJUSTMENT		
Difficulty getting along with other children	○	○
Difficulty with changes in routine	○	○
Easily frustrated	○	○
Impulsive	○	○
Prone to tantrums	○	○
Low self-esteem	○	○
Avoids eye contact	○	○
Prefers parallel or solitaire play	○	○
Anxious	○	○

Describe past services (speech, physical therapy, occupational therapy, vision therapy, tutoring, counselling, and other)

_____

_____

Academic Difficulties (check any that may apply to your child)

◯ Reading	◯ Restless	◯ Poorly Organized	◯ Short attention
◯ Math	◯ Distractible	◯ Finishing Tasks	◯ Poor memory
◯ Spelling	◯ Messy work	◯ Following directions	◯ Handwriting

Describe your child's **personality**.

_____

_____

_____

_____

List your child's **strengths** (academic, physical, artistic, musical, and behavioral).

_____

_____

Describe your specific **concerns** about your child's development.

_____

_____

What does your child enjoy doing in his/her **free-time** (lessons, hobbies, sports, etc.)?

_____

_____

What are your **goals and expectations** for Occupational Therapy?

_____

_____

_____

_____