OT4LIFE
OCCUPATIONAL THERAPY FOR CHILDREN

Phone: 561-419-3944 • Email: info@ot4lifeflorida.com

Contact Information and Background Questionnaire

DATE: ______________

CHILD'S FIRST NAME: ________________________ **LAST NAME:** _______________________

Date of birth: ____________________ Age: ________ Nickname: __________________________

Child's address: ____

City: ___________________________________ State: ___________ Zip Code: ______________

Primary Contact Phone: (______) _____________

Known Allergies: (food, medication, other) ____

PARENTS/GUARDIANS responsible for child's treatment:

1. FIRST NAME: ___________________________ **LAST NAME:** ____________________________

Relationship to child: _________________________ Occupation: ______________________________

Cell Phone: (______) _________________________ Email: ___________________________________

Preferred Contact Method(s): ☐ Phone Call ☐ Text ☐ Email

2. FIRST NAME: ___________________________ **LAST NAME:** ____________________________

Relationship to child: _________________________ Occupation: ______________________________

Cell Phone: (______) _________________________ Email: ___________________________________

Preferred Contact Method(s): ☐ Phone Call ☐ Text ☐ Email

Emergency Contact Full Name: ____

Relationship to Child: ___________________________ Phone: (______) ___________________

Diagnosis (if applicable), and date diagnosis was made:

____

Child's Primary Physician's Name: ____

Physician's Phone Number: _________________________ Fax Number: _____________________

Physician's Address: ____

Other Physicians / Specialists Involved In Child's Care:

Name of Physician: ______________________________ Phone Number ______________

Physician's Address: ____

Name of Physician: ______________________________ Phone Number ______________

Physician's Address: ____

Referred to OT4LIFE by: ____

Please describe the reason for your child's referral for occupational therapy and your primary concerns:

____

____

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____

At what age did you first notice the issues you have concerns about? ______________________

How do your child's difficulties impact your family? ______________________________

____

____

Names of siblings living in the home:

1. ________________________________ Age: _______ ☐ Male ☐ Female

2. ________________________________ Age. _______ ☐ Male ☐ Female

3. ________________________________ Age: _______ ☐ Male ☐ Female

Does your family have pets? ☐ Yes ☐ No How many? ____ ☐ Dog(s) ☐ Cat(s) ☐ Other(s)

Is there anything additional you would like to share about your family / home environment?

____

____

Medical and Developmental History:

List any complications, illness, infection during pregnancy:

____

____

Child Delivered: Vaginally ____ C-section ____

Born at: ______ weeks gestation (40 weeks is typical)

List any complications during labor and delivery:

____

____

Breast fed Yes ____ No ____ If Yes, for how long? ___________

Describe any difficulty with breast feeding:

____

____

Describe any problems your child had with feeding, respiration, sleeping (as a baby):

____

____

____

Describe the general demeanor of your child as an infant (i.e. irritable, colicky, easy going, quiet)

____

Approximate age your child met the following developmental milestones:

Sat _______ Belly Crawled _______ Crawled ______ Walked ______

Said 1st words _______ Talked ________ Toilet trained: Bladder _______ Bowels ______

Preferred hand: LEFT _____ RIGHT _____ Age established ______ Not yet established _____

List any significant illnesses, complications, chronic conditions, hospitalizations, or accidents that your child has experienced since birth (i.e. recurrent ear infections, seizures, allergies, etc.):

____

____

____

Does your child wear glasses (if yes, indicate for which condition) ☐ Yes ☐ No

____

List any medication(s) or supplement(s) your child is currently taking as well as the purpose(s):

____

____

____

School / Educational Information:

Is your child currently enrolled in daycare or school? ☐ Yes ☐ No If preschool: ☐ AM ☐PM

What day(s) does your child attend? ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Grade your child is in: ________________ Type of Classroom: __________________________

Public School: ☐ Yes ☐ No School District: _______________________________________

School name: __________________________________ School phone number: ____________________

School address:____

Number of students in your child's classroom: _______ Number of staff in the classroom: ______

List any services your child currently receives **at school** (OT, PT, APE, Resources, Speech, etc)

____

____

Therapy History / Areas of Concern:

List any services your child **currently** receives **outside of school** (OT, PT, ABA, Tutoring, etc)

____

____

List any therapies or instruction your child received **in the past** (OT, PT, Speech, Neuropsychology, ABA, etc)

1. Therapy: ______________________________________ Dates received: _______________________
2. Therapy: ______________________________________ Dates received: _______________________
3. Therapy: ______________________________________ Dates received: _______________________
4. Therapy: ______________________________________ Dates received: _______________________

Does your child have difficulty with any of the following (Please check any that apply):

☐ Attention ☐ Emotional Regulation / Frustration Tolerance

- ☐ Postural Control
- ☐ Balance
- ☐ Coordination
- ☐ Play Skills
- ☐ Social Interaction
- ☐ Making/maintaining eye contact
- ☐ Following directions
- ☐ Transitions
- ☐ Fine Motor Skills
- ☐ Handwriting
- ☐ Sleep
- ☐ Dressing
- ☐ Grooming
- ☐ Educational Participation

Social History:

Describe how your child interacts with parents, siblings, or other family members:

____

____

____

Please list any significant changes your child/family has experienced in the past year (move, loss of a loved one, serious illness [self or family member], etc…):

____

____

What are your child's strengths?

____

____

____

What are your child's weaknesses?

____

____

____

What are your child's favorite activities?

____

____

____

Which community activities (ex. play groups, dance, sports, etc…) does your child participate in, and how is his/her behavior and interaction with others?

____

Does your child become easily frustrated with certain activities? If so, please explain:

Describe how your child interacts with other children:

What are your goals for your child's therapy:

Play Preferences:

What are your child's favorite toys/games?

Does your child tend to select active or sedentary (seated, quiet) play?

Does your child demonstrate imaginative play themes? ☐ Yes ☐ No

Is there anything else that is important for us to know about your child?