PlaySteps for Developing Kids LLC
...let's play for a change

Information Form for OT Consultation

Date

Parents' names

Full address

Phone number

Email

Child's name

Child's birthdate

School and grade level

Other professionals (doctor, psychologist, speech therapist, educational specialist) working with child:

Referred by

Dear Parent/Guardian,
We are pleased that you have contacted our clinic. We would appreciate your answering those questions below which pertain to your child's needs and developmental goals. All information will be kept completely confidential. We look forward to connecting with you personally in the very near future.

Jeff Marks, Director, PlaySteps for Developing Kids

Areas of concern for your child and what you hope to gain from therapy:

Please check the appropriate box for each yes/no question below.

Handwriting Skills

1. Does your child:
   - hold the pencil in an unconventional way? yes no
   - tend to write faster than peers? yes no
   - tend to write more slowly than peers? yes no
   - avoid handwriting instruction? (for younger children) yes no
   - minimize/avoid writing? (for older children) yes no
   - respond more fully when writing isn't required? yes no
   - complain of hand fatigue, or shake out hand after a few minutes? yes no
2. Is the writing itself hard to read? yes no
3. Does the quality of the writing decline after the first minute or two? yes no

4. Has handwriting always been a challenge for your child? yes no

If yes on any of the above questions, please explain:

Fine Motor Skills

1. Does your child have difficulties with self-care skills such as:
   - holding eating utensils (continuing to use an in-palm grasp rather than 1st three fingers)? yes no
   - opening food containers? yes no
   - manipulating buttons/snaps, connecting zipper sides? yes no
   - tying his/her shoes? yes no
2. Is there any difficulty using the two hands together, such as:
   - cutting with scissors? yes no
   - coloring (holding the paper with the non-dominant hand)? yes no
   - stringing beads? yes no
   - holding an object with one hand and manipulating it with the other? yes no
3. Is there an absence of consistent hand preference? yes no
   Or is right/left hand preference inconsistent? yes no

If yes on any of the above questions, please explain:

Gross Motor Skills

1. Does your child have difficulties with gross motor skills such as:
   - jumping with two feet? yes no
   - hopping on one foot? yes no
   - running? yes no
   - skipping? yes no
   - climbing? yes no
   - riding a bike? yes no
   - pumping a swing? yes no
   - sitting upright at a desk/table? yes no
2. Does your child bump into things or people or misjudge space often? yes no
3. Does maintaining his/her balance seem to be a challenge for your child? yes no
4. Does your child have difficulty learning new movement sequences (e.g. swimming lessons, martial arts, gymnastics)? yes no
5. Does your child avoid movement activities? yes no

If yes on any of the above questions, please explain:

Sensory Modulation

1. Is your child over or under responsive to:

sound?	yes	no
touch?	yes	no
movement?	yes	no

If yes on any of the above, please answer the following

questions: Does your child (compared to other children) seem:

• more bothered than others by loud noises or noisy environments?	yes	no
• more likely to notice background noises?	yes	no
• more likely to not notice sound at all?	yes	no
• bothered by tags and seams, or certain clothing textures?	yes	no
• upset with grooming tasks (e.g. brushing teeth or hair, haircuts, sunscreen, etc.)?	yes	no
• upset and/or "rubs out" the area touched when touched unexpectedly?	yes	no
• to react differently to pain?	yes	no
• distressed by or will avoid messy stuff?	yes	no
• to seek messy play?	yes	no
• not to notice if he/she has food on his/her face?	yes	no
• to seek strong hugs and/or push into people?	yes	no
• to be a picky eater?	yes	no
• to avoid/refuse certain food textures?	yes	no
• to avoid certain kinds of movement?	yes	no
• to seek certain kinds of movement?	yes	no
• to exhibit increased or decreased attention, impulsivity and activity level in different situations or environments?	yes	no
• to have trouble remaining in busy or group situations (e.g. restaurants, indoor gyms, standing in line)?	yes	no

If yes on any of the above questions, please explain:

What are the biggest factors that impede your child's performance?

Functional Vision and Perception

1. Does your child have difficulty with visual tasks such as:
    - lining up math problems?
    - spacing and sizing letters and words?
    - copying from the white board?
    - skipping words or losing place when reading?
    - reversals of words or letters beyond 1st grade?
    - eye fatigue or headaches?

Infant & Toddler Behaviors (Please only fill out this section if your child is an infant or toddler.)

1. What are your child's night time and nap time sleep patterns?

2. Does your child have any feeding or diet challenges?

3. Describe your child's emotional regulation. Does he/she experience fussiness, tantrums, inflexibility, or inability to self-soothe?

4. Describe your child's social engagement with adults and other children.

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5. Does/did your child have an adequate suck when using a bottle or nursing? yes no
6. Do you feel your child is unusually floppy? yes no
7. Do you feel your child is unusually stiff? yes no

8. Describe your child's sitting posture on the floor or in a chair.

9. Do you have any concerns regarding the timing of your child reaching his/her developmental milestones (e.g. gross motor, fine motor, feeding and speech)?

Thank you very much for taking the time to answer these questions about your child. The insight and information you have provided will be extremely helpful as we prepare for your 30-minute phone consultation with one of our therapists regarding your child's needs, and how they might be addressed through Occupational Therapy. To help in the scheduling of your complimentary consultation, please tell us what days/times are most convenient for you for scheduling your call:

days of the week*(M-F)* _____ ***times of the day***_____

Permission for Electronic Communication *(Please initial only ONE.)*
Information sent by unencrypted email poses some risk that the content could be read by a third party. I have been apprised of this risk and agree to receive communications via email.

OR

The use of unencrypted e-mail is unacceptable and I request all confidential communications by mail, telephone or in-person. Initials

Again, thankyou for contacting us at PlaySteps.

Warm regards,
Jeff Marks, Director