



Occupational Therapy Evaluation Questionnaire

Child's Name: _____ Today's Date: _____

Parents' Names: _____

Home Phone: _____ Emergency Contact: _____

School and Grade: _____ Date of Birth: _____

Please list ages and relationships of persons living in the home with the child:

Parents: _____

Siblings: _____

Other: _____

Diagnosis: _____

Referring Physician: _____

Reason for Referral: _____

Background Information:

Full Term Pregnancy No Pregnancy or Birth Complications

Gestational weeks: _____ Birth Weight: _____

Complications During Pregnancy/Delivery _____

Medications Used During Pregnancy: _____

Premature Birth Number of Weeks Premature: _____

Oxygen Length of time: _____

Feeding Tube Length of time: _____

NICU Length of time: _____

Newborn Medications: _____

Newborn Surgeries: _____

Childhood Hospitalizations and/or Surgeries:

Age: _____ Reason: _____

Age: _____ Reason: _____

Age: _____ Reason: _____

Age: _____ Reason: _____

Medications:

Past: (please list ages) _____

Current: _____

Therapies:

Past: (please list ages) _____

Current: _____

Allergies: _____

On a scale of 1 to 4, how well does the child function in the following areas? (circle one)

1 = Completely dependent on others. Needs lots of help or cues.

4 = Completely independent. No difficulties in this area.

Dressing Upper Body	1	2	3	4	Not Applicable
Dressing Lower Body	1	2	3	4	Not Applicable
Toileting	1	2	3	4	Not Applicable
Eating (breast or bottle)	1	2	3	4	Not Applicable
Eating (soft foods off spoon)	1	2	3	4	Not Applicable
Eating (with fingers)	1	2	3	4	Not Applicable
Eating (with utensils)	1	2	3	4	Not Applicable
Playing with familiar peers	1	2	3	4	Not Applicable
Playing with unfamiliar peers	1	2	3	4	Not Applicable
Handwriting	1	2	3	4	Not Applicable
Frustration tolerance	1	2	3	4	Not Applicable
Sleeping routine	1	2	3	4	Not Applicable
Grooming (hair)	1	2	3	4	Not Applicable
Grooming (bathing)	1	2	3	4	Not Applicable
Grooming (teeth)	1	2	3	4	Not Applicable
Maintaining attention to tasks	1	2	3	4	Not Applicable
Entertaining self	1	2	3	4	Not Applicable
Hand/Eye coordination	1	2	3	4	Not Applicable
Balance	1	2	3	4	Not Applicable
Following verbal directions	1	2	3	4	Not Applicable
Safety awareness	1	2	3	4	Not Applicable
Cutting with scissors	1	2	3	4	Not Applicable

Please list your child's strengths: _____

Please list your child's weaknesses: _____

What are your goals for therapy? _____

Please let us know your child's favorite things:

Food: _____

Snack: _____

Drink: _____

Candy: _____

Toy: _____

Game: _____

Activity: _____

TV show/Movie: _____

Other Favorites: _____

Please use back of page to share any information we have omitted on these two pages.