FUNctionabilities Occupational Therapy

Pre-Exam Questionnaire Ages 0 – 2.11

To more fully evaluate your child's deficits, please be as accurate as possible. Thank you.

Child's Name: _____ Date of Birth: _____

Birth and Medical History

1. Were there any difficulties or complications during pregnancy, at, or shortly after birth? ☐ Yes (Please explain below) ☐ No

2. Describe your child's behavior before the age of 1**(please check all that apply):** ☐Easy ☐Difficult ☐Active ☐Passive ☐Quiet ☐Enjoyed cuddling ☐Resisted being held ☐Sociable ☐Cried a lot ☐Tense when held ☐Good sleep patterns ☐Bad sleep patterns ☐Excessive restlessness ☐Head banging

3. List all medical conditions your child has (or you have been told your child has) - if your child has a history of seizures, include the actions you would like us to take if your child has a seizure:

4. Is your child taking any medication(s)? ☐ Yes (Please list medication and what it's treating below) ☐ No

   - If yes, do you feel it is helping? ☐ Yes ☐ No

5. List all past surgeries and major injuries with dates:

6. Please list any allergies that your child has (include recommended reactions to allergens):

Developmental History

Please mark the following based on your child's behavior before the age of 1:
☐ Smile spontaneously at people ☐ Copy facial expressions (smile/frown) ☐ Imitate sounds ☐ Let you now he/she was happy/sad
☐ Follow moving toys with eyes ☐ Pick up small objects ☐ Tried to get out-of-reach items ☐ Move objects from hand to hand
☐ Use fingers to point ☐ Look for things he/she sees you hide ☐ Plays peek-a-boo ☐ Picks up items with thumb & index finger
☐ Clap hands 2-3 times ☐ Crawls well

Please mark the following based on your child's behavior from 12 – 18 Months old:
☐ Shows fear ☐Repeat sounds/actions for attention ☐Respond to simple requests ☐Use gestures -shake head 'no', wave 'bye-bye'
☐ Begins to use items (cup, brush) ☐ Put things in/take out of containers ☐ Turn thick pages in book ☐ Grasp large crayon in fist
☐ Cruise (walk holding furniture) ☐ Helps with dressing ☐ Know use of basic items (phone, spoon) ☐ Point to one body part

Please mark the following based on your child's behavior from 18 – 24 Months old:
☐Scribble ☐ Puts basic shapes in holes ☐Stack 3-4 blocks ☐Turn pages in a book ☐Walks up 3 steps, 2 feet per step, holds 1 hand
☐ Helps get undressed ☐ Drinks from a cup ☐ Uses one hand more than the other ☐ Throws a small ball

Please mark the following based on your child's behavior from 24 – 35 Months old:
☐ Play mainly near other children ☐ Point to item when it's named ☐ Know names of familiar people ☐Knows body parts
☐ Follows simple instructions ☐Sorts shapes and colors ☐Plays make-believe ☐ Stacks 7 blocks ☐ Imitates vertical line on paper
☐ Thread beads or holes with shoelace ☐ Kicks a ball ☐ Runs ☐ Jumps with both feet ☐ Climb on/down from furniture

Therapy / Educational History

1. Please list all other past and current therapy, medical, and psychological services/evaluations:

2. Does your child comprehend directions as well as other children? ☐ Yes ☐ No

3. Your child's level of intellegence compared to other children? ☐ Below average ☐ Average ☐ Above average

Occupational History

1. What activities does your child love doing the most?

2. What are your child's greatest accomplishments?

3. What does your child dislike the most?

4. Does your child have difficulty with daily routines? Please describe:

5. Describe your child at present: **(Please check all that apply):** ☐ Tires easily ☐ Resistant to change ☐ Aggressive ☐ Typically happy ☐ Frequent tantrums ☐ Poor attention ☐ More active than peers ☐ Heedless of danger ☐ Has excessive accidents/injuries ☐ Doesn't learn from experience ☐ Over reacts to touch/noise

1. What are your primary concerns? (Describe below)

2. Are your family's everyday activities affected? ☐ Yes (Describe below) ☐ No

3. When did it start? _____ Is it getting: ☐ Worse ☐ Better ☐ Staying the same

4. How often do you experience these problems with your child?

5. On the scale below circle your worst level for the child's problem(s) in the past couple of days:

Mild *Moderate* *Severe*
0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10

Patient Name:_____ Parent Signature:_____Date _____