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Date ______/______/______

NEW PATIENT INITIAL EVALUATION QUESTIONNAIRE

(Physical/ Occupational and Speech Therapy)

Patient Name: _________________________________ Date of Birth: ________________ Sex: M F

Medical or Developmental Diagnosis: ____

Language(s) Spoken at Home if other than English: ____

Parent(s) or Guardian(s) name(s): ____

Person Completing Questionnaire: _________________________ Relationship to Child: __________

Please Answer the following questions and circle below (if applicable)

Has your child had previous therapy before?	YES NO
What service(s) were they receiving?	Physical Therapy/Occupational Therapy/Speech Therapy
How long did they attend therapy?	
Where?	

What is your current concern(s) that you may have? What would you like your child to be doing that they are currently not able to do?

____

____

BIRTH/ MEDICAL HISTORY:

Was your child born **Full Term/Preterm** (circle) **Vaginal birth/ C-Section** (circle)

If preterm, gestational age at birth: ____________________

Were there any issues/complaints during your pregnancy? **YES/NO** (circle)

If yes, please describe: ____

____

Did your child have to stay in the NICU after birth? **YES/NO** (circle) if yes, how many days: _________

What treatments were provided?

____

____

Is your child currently taking any medications/ supplements? **YES/NO** (circle) If yes, please list below:

_________________________ _________________________ _________________________

_________________________ _________________________ _________________________

_________________________ _________________________ _________________________

Has your child been recently hospitalized? **YES/NO** (circle) If yes, when/why:
____

Describe any illness, feeding, sleeping, or behavior problems during the first few months of life:
____
____

Did your child experience any of the following (if so, at what age)?

Jaundice______ Colic______ Measles______ Mumps______

Rubella______ Pneumonia______ Croup______ Other______________________

Does your child have any of these problems (please put a check or list what applies)?

Asthma ______ Seizures______ Headaches______

Food Allergies: ____

Other Allergies: ____

Any injuries or surgery: ____

List any other health precautions, limitations or diet restrictions you would like the therapist to know:

____
____

Does your child have a history of frequent ear infections? **YES/NO** (circle) Age Started: _______________

If yes, how many infections did he/she have in the past year? ______________________________________

Does your child have ear (PE) tubes? **YES/NO** (circle)

Has your child's hearing been test? **YES/NO** (circle)

If yes, when/where: ___________________________________ Results: ______________________________

Has your child's vision been test? **YES/NO** (circle)

If yes, when/where: ___________________________________ Results: ______________________________

Does your child use any of the following at home or at school? (Check all the applies)

___Walker ___Wheelchair ___Special cups/spoons ___Pacifier

___Sippy cup ___Helmet ___Assistive Technology ___Orthotics

___Infant Swing ___Exersaucer ___Bottle

___Infant "Walker" or Jumper ___Other: ______________________________

DEVELOPMENTAL HISTORY:

Motor/Sensorimotor. At what age did your child (Leave blank if child has not met skill yet):

_____Lift head while on stomach

_____Roll over front to back

_____Sit alone

_____Crawl on all fours

_____Stand alone

_____Walk holding on to the furniture

_____Walked independently

_____Give up a bottle during the night

_____Drink from a straw

_____Drink from a cup without help

_____Use a spoon

_____Stop wearing diapers during the day

_____Pedal a tricycle

_____Ride a bike

_____Walk downstairs unassisted

Does he/she avoid:

Touching things or getting dirty? **YES/NO** (circle)

Cover ears or hide head around certain noises? **YES/NO** (circle)

Blink excessively or blink when a ball is thrown to him/her? **YES/NO** (circle)

Can your child throw a ball? **YES/NO** (circle)

Catch a ball? **YES/NO** (circle)

Which hand is used most often? ____

Dressing Skills: **For Occupational Therapy**

(Please circle response to all that applies)

Child can independently dress self?	**YES**	**NO**	**Need Help**
Child can zip and button clothing?	**YES**	**NO**	**Need Help**
Child needs occasional assistance to dress?	**YES**	**NO**	**Need Help**
Child is starting to push arms through sleeves; legs through pant legs?	**YES**	**NO**	**Need Help**
Remove shoes	**YES**	**NO**	**Need Help**
Put on shoes	**YES**	**NO**	**Need Help**
Can tie/untie shoes	**YES**	**NO**	**Need Help**

Speech and Hearing: **For Speech/Occupational Therapy**

Did your child **babble** or **coo** or **both**? (circle) Did it increase after 6 months? **YES/ NO** (circle)

When did he/she:

Speak first word? ______________________

Put two words together? ______________________

Speak in short sentences? ______________________

Please check any terms that apply to your child:

__ No speech present __ Rarely speaks __ Lack of response when spoken to

__Speaks too fast __Keeps mouth open __Often seems to ignore when spoken to

__ Speaks too softly __ Drools __ Can't begin speaking easily or stutters

__ Speaks too loudly __ Tongue thrust __ Speech is not understandable

__ Voice is hoarse __ Only uses one-word utterances

__ Voice is nasal __ Can't find the words __ Difficulty chewing or swallowing

__ High pitch __ Yells __ Complains of ear pain

__ Talks but can't get to the point

Motor Skills/ Social Interaction/Sensory: **For Physical/Occupational Therapy**

(Please circle response to all that applies)

Child appears clumsy or uncoordinated? **YES/NO**

Child has difficulties with handwriting? **YES/NO**

Child fatigues easily and has poor endurance? **YES/NO**

Child has difficulties learning new motor skills? **YES/NO**

Does your child have difficulties with transitions to new activities/environments? **YES/NO**

Does your child have difficulties with change in routine? **YES/NO**

Does your child have poor safety awareness in the community? **YES/NO**

If your child is upset or angry, do they have difficulties calming and coping with anger? **YES/NO**

Comments: ____

Do you have concerns about your child's ability to play with other children? **YES/NO**

Does your child have significant fear, aversion or difficulties with the following items?

Washing/cutting hair **YES/NO**

Cutting fingernails **YES/NO**

Brushing teeth/ oral care **YES/NO**

Loud and unexpected sounds **YES/NO**

Clothing textures/fabric **YES/NO**

Avoids swings/climbing/movement **YES/NO**

Avoids messy play/ getting dirty **YES/NO**

EDUCATIONAL: (only if applicable)

Name of School ______________________________ City/County _____________________ Grade _____

Services at School: (please check)

__ Individual Family Service Plan (ISFP) __Individual Education Plan (IEP) __ Adapted PE

__ Physical Therapy __Occupational Therapy __Speech Therapy __ Classroom Aide

__ Other: ____