

MAXIMUM POTENTIAL

Pediatric Occupational Therapy
Specializing in Sensory Integration

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Parents Questionnaire For Occupational Therapy Evaluation

Child's Name: _____ Sex/DOB: _____

Father's Name: _____ Occupation: _____

Mother's Name: _____ Occupation: _____

Phone Number: _____

Mobile Number _____

Home Address _____

Email _____

Parent's Marital Status: Married/Divorced/Single/Widowed/Separated

School Child attends _____ Year _____

Other Children: _____

Has any family member had any medical problem? Please Specify:

Is any member of your family left-handed? _____ or ambidextrous? _____

When did you first notice your child having a problem?

What did you observe?

II. BIRTH AND MEDICAL HISTORY

Pregnancy:

Were there any illnesses, injuries, bleedings or other complications? _____

Was there any medication given? _____

Were you under emotional stress? _____

Delivery / Birth:

Was the pregnancy:

full term? Premature? months weight:

Type of delivery:

spontaneous caesarian breech others

Length of labour:

normal prolonged Apgar Score

Was there a need for oxygen? Transfusions? Tube feeding?

Did your child stay in hospital unusually long?

Was your child breast fed? How long? Bottle fed?

Comments:

Your child's Medical Consultant? Hospital

Has your child had an eye evaluation? By Whom?

Date Result

Has your child had a hearing test? By Whom?

Date Result

List any other medical conditions and treatment received in the past and at present:

Other services involved (list name, location and duration)

Educational Psychologist

Speech / Language Therapist

Physiotherapist

Others

III. DEVELOPMENTAL HISTORY

Describe your child as a baby (circle as appropriate)

passive	active	cried a lot, fussy, irritable	was good	quiet
non-demanding	alert	had good / irregular sleep patterns		
liked / resisted being held		floppy / tense when held		

When did your child...

roll over	sit alone	crawl	stand alone	walk alone
show hand preference		spek the 1 st word	spek the 1 st sentence	

Comments:

Describe you child at present

Mostly quiet	overly active	tires easily	talks constantly	impulsive
Restless	stubborn	is resistant to change	over-reacts	fightes frequently
Is usually happy	has frequent temper tantrums	falls often	wets bed	
Has unusual fear	is frustrated easily	affectionate	poor attention span	
Has difficulties learning a new task		has difficulties separating from mother / father		
Sensitive to criticism	has trouble 'growing up'	likes to mix with other children		

Comments:

Independence

When did/was your child... (if unable please state 'A' for 'assistance needed' and 'D' for 'dependent')

..toilet trained:	day time	night time			
Drink from a cup independently	use a spoon independently				
Use a knife and fork independently					
...take off:	shoes	socks	trousers	shirt	t-shirt
...and put on:					
...undo:	buttons	shoelaces	buckles		
...and do:					
...brush his/her teeth		wash his/her face			

Comments:

IV. SENSORY PROCESSING FUNCTIONS

Please check (✓) the response that best describes your child’s behaviour. Add any additional comments where appropriate. Also include your child’s strengths. If you are unable to answer some questions please indicate by drawing a line through all the responses (—————) . Use the following key to determine the answer.

Key to responses:

1. always: when presented with the opportunity, the child responds in the manner every time; 100%
2. frequently: when presented with the opportunity, the child usually responds in the manner; at least 75%
3. occasionally: when presented with the opportunity, the child sometimes responds in the manner; 50%
4. seldom: when presented with the opportunity, the child rarely responds in this manner; 25%
5. never: 0%

A. AUDITORY / HEARING

	Always	Frequently	Occasionally	Seldom	Never
1. Responds negatively to unexpected or loud noise (e.g., vacuum cleaner, dog)					
2. Is distracted or has trouble functioning if there is a lot of noise around					
3. Seems confused as to direction of sound					
4. Enjoys strange noises / seeks to make noises					
5. Enjoys music					
6. Appears not to hear what you say					

Comments:

B. VISUAL

	Always	Frequently	Occasionally	Seldom	Never
1. Looks carefully or intently at people					
2. Happy to be in the dark					
3. Gets lost easily					
4. Hesitates going up or down kerbs					
5. Expresses discomfort at bright lights					
6. Puts puzzles together easily					
7. Has a hard time finding objects in competing background (e.g., favourite toy in the toy box)					
8. Has trouble staying within the lines when colouring or when writing					

Comments:

C. TASTE / SMELL

	Always	Frequently	Occasionally	Seldom	Never
1. Acts as though all food tastes the same					
2. Shows preferences for certain tastes (list below)					
3. Craves certain foods (list below)					
4. Dislikes certain foods or textures					
5. Chews / licks on non-food objects					
6. Deliberately smells objects					
7. Shows preferences for certain smells (list below)					

Comments:

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D. TOUCH

	Always	Frequently	Occasionally	Seldom	Never
1. Avoids getting hands messy (e.g., paste, sand, paint)					
2. Becomes upset when being washed					
3. Expresses distress over having hair cut, combed or washed					
4. Expresses distress over being bathed, having finger nails cut					
5. Prefers long sleeved clothing, sweaters, or jackets even when it is warm					
6. Expresses discomfort when people touch; even in friendly hug or pat					
7. Expresses discomfort when getting teeth brushed					
8. Expresses unusual need for touching certain toys, surfaces or textures					
9. Is sensitive to certain fabrics; avoids wearing clothes made of them					
10. Avoids going bare foot, especially in sand or grass					
11. Avoids wearing shoes; loves to be bare foot					
12. Tends to feel less pain than others					
13. Tends to feel more pain than others					
14. Isolates him / herself from other children / people					

Comments:

E. MOVEMENT

	Always	Frequently	Occasionally	Seldom	Never
1. Becomes anxious or distressed when feet leave ground					
2. Fears falling or heights					
3. Dislikes activities where head is upside down (e.g., somersault) or rough play					
4. Avoids playground equipment or moving toys					
5. Rocks unconsciously during other activities (e.g., whilst watching television)					
6. Avoids climbing, jumping, bumpy or uneven ground					
7. Seeks out all kinds of movement activities (e.g., being whirled by adult, merry-go-rounds)					
8. Takes risks during play (e.g., climbs high into a tree, jumps off tall furniture)					
9. Dislikes riding in a car					

Comments:

F. BODY POSITION

	Always	Frequently	Occasionally	Seldom	Never
1. Seems to have weak muscles					
2. Tires easily, especially when standing or holding a particular body position					
3. Walks on toes					
4. Holds body in strange positions for periods of time					
5. Locks joints (e.g., elbows, knees) for stability					

Comments:

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G. ADDITIONAL INFORMATION

Completed by _____ Date: _____

THANK YOU FOR YOUR COOPERATION