Advanced Therapy Solutions

CLIENT HISTORY QUESTIONNAIRE

Date: _____

GENERAL INFORMATION

Child's Name: _____ Date of Birth: _____

Height: _____Weight: _____Hair/Eye Color: _____

Parent/Guardians: _____

Address: _____

Home Phone: _____ Cell Phone: _____ E-mail: _____

Best way to reach you: (Daytime) _____ (Evening) _____

Parent #1 Place of Employment: _____

Employment Address: _____

_____Work Phone:_____

Parent #2 Place of Employment: _____

Employment Address: _____

_____ Work Phone: _____

Health Insurance Company: _____

Policy/ID #_____ Social Security # of Policy Holder_____

Subscriber of Health Insurance: _____DOB:_____

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Main Areas of Concern: _____

_____

Who referred child for Occupational Therapy Services: _____

Primary Diagnosis: _____ Secondary Diagnosis: _____

Primary Care Physician: _____

DEVELOPMENTAL AND MEDICAL HISTORY

1. Please describe your child's birth history. List any complications during pregnancy, birth or infancy.

_____

_____

_____

2. Please give the approximate age that your child accomplished major developmental milestones.
   Please include: sitting independently, crawling, walking, reaching, talking, etc.

_____

_____

_____

3. Please describe any developmental challenges your child has faced or continues to face.

_____

_____

_____

Please use the following scale to describe your child's behavior:

1 – Never or rarely exhibits this behavior
2 – Occasionally exhibits this behavior
3 – Exhibits this behavior as much as is typical for a child of this age
4 – Exhibits this behavior somewhat more often than expected
5 – Very frequently exhibits this behavior

4. Diarrhea __ 5. Stomachache __ 6. Vomiting __ 7. Headache __ 8. Constipation __ 9. Earache __

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10. Does your child have a history of ear infections? If yes, please describe frequency of occurrence and how the ear infections have been medically treated. _____

_____

_____

11. Does your child have any allergies? If yes, please list what your child is allergic to, how these allergies are medically managed and any behaviors your child exhibits that you think are related to either the allergies or the allergy medications. _____

_____

_____

12. Does your child currently take any medications? If yes, please list the medications, dosages and for what condition the medication is taken. Also, please list any behaviors your child exhibits that you believe might be attributed to the medications. _____

_____

_____

Please check any of the following with whom you have had contact concerning your child. Please provide name and address:

[ ] Psychologist

Name and Address: _____

[ ] Neurologist

Name and Address: _____

[ ] Physical Therapist

Name and Address: _____

[ ] Speech Therapist

Name and Address: _____

[ ] Resource of Special Teacher

Name and Address: _____

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SCHOOL HISTORY

What is your child's current grade? _____ Teacher's Name: _____

What school does your child attend at this time? _____

Has your child had any formal evaluations/testing? If yes, what and when?

_____

_____

_____

Are there Behavioral/Emotional issues? If yes, please describe. _____

_____

_____

_____

How does your child communicate primarily? Has he/she received speech services? If yes, for what? (i.e. expressive receptive language, pragmatics)

_____

_____

_____

If your child is nonverbal, please describe how your child communicates and give examples. _____

_____

_____

If your child is verbal, please describe your child's verbal abilities (i.e. vocabulary, ability to stay on topic, etc.)

_____

_____

_____

Please list siblings or other adults and children that live in the same home as your child:

_____

_____

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SELF-CARE/DAILY ROUTINES

MEALTIME:

Please describe a typical mealtime with your child. Include where, what and how your child eats, your child's typical appetite, the number of meals and snacks your child has each day, your child's behavior during mealtimes, etc.

Please describe how your child typically gets dressed. Include the types of clothing your child wears, how independent your child is with his/her clothing, how long it takes your child to dress, your child's behavior during dressing, etc.

Please describe a typical bath time for your child. Include your child's level of independence in bathing, your child's like or dislike for bath time, your child's behavior during bath time, etc.

Please describe your child's behavior and level of independence for each of the following tasks:

Teeth brushing: _____

Hair brushing: _____

Washing hands and face: _____

Please describe your child's toilet skills. Include level of independence, frequency of occurrences of bed- wetting, frequency of occurrences of daytime bowel and bladder accidents, awareness of toileting needs, etc.

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Please describe how your child makes transitions between people or environments. Include level of independence during transitions, needs for transitional objects, need for advance preparation about schedule change, etc.

_____

_____

If applicable, please describe how your child completes homework. Include level of independence, need for breaks, need for external supports (food, music, etc.), the amount of time typically needed, etc.

_____

_____

Please describe your child's ability to independently keep track of personal belongings.

_____

_____

Please describe your child's ability to independently organize personal belongings (homework, bedroom, desk, etc.).

_____

_____

Please describe your child's typical play skills. Include information about the ages of the people your child chooses to play with, if your child chooses to be a leader, a follower or a loaner, how many people your child is comfortable playing with at once, whether your child prefers a few close friends or a lot of acquaintances, etc.

_____

_____

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