INITIAL QUESTIONNAIRE
OCCUPATIONAL THERAPY

To provide you with the best possible service, we have created this questionnaire in order to get a preliminary idea of your child's history, strengths, weaknesses and level of functioning in daily life. The occupational therapist in charge of your file will review the answers you provide in this questionnaire prior to your initial meeting. Please be as thorough as possible and let us know if you have any questions.

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What are your concerns as it pertains to your child? (motivation for services)

What are your expectations in occupational therapy?

Medical history
Diagnosis:
Medication:
Surgical intervention:

Specialist	Name	Location	Date	Available report (Y/N)
Pediatrician				
Audiologist				
E.N.T.				
Speech therapist				
Occupational therapist				
Physical therapist				
Psychologist				
Psychiatrist				
Social worker				
Neurologist				

Nurse				
Nutritionist				
Psychoeducation				
Special care counselor				
Other				

* Please send reports if possible

Pregnancy & Delivery
How would you describe your pregnancy?
How would you describe your labour & delivery?

Neonatal period
Location of birth:
Weight at birth:
APGAR:

Developmental profile (indicate age of child when they achieved the following milestones)
Rolling from back to stomach:
Rolling from stomach to back:
Maintained sitting position:
Crawled:
Walked:
Ride a bike / tricycle:
Go down the stairs:
Catch a ball:

Developmental profile (describe ability of the child)
Ability to hold a crayon:

Ability to hold scissors:
Cutting with scissors:
Pick up small objects:
Coloring:
Do up buttons:

Physical & Social environment
The child lives with:
Siblings (how many and what age)?
Does the child have good relationships with family members?
What are the languages spoken at home?

Childcare
Name of childcare institution:
Phone number:
Private daycare or CPE:
Number of days per week:
Functioning:

School
Name of school:
Phone number:
Academic level:
Name of teacher:
Is the child receiving additional services:

Functioning:

Nutrition
Did your child breastfeed:
Accept purees with pieces:
Tend to be selective or difficult with food choices:
Tend to swallow food whole:
Can your child use a spoon:
Use a fork:
Use a knife to spread:
Use a knife to cut:
Drink from a sippy cup:
Drink from a regular cup:
Open containers:
Eat cleanly:
Other comments:

Sleep habits
What is your child's average bedtime:
Does your child take a nap, if so at what time:
What is the bedtime routine:
What is the quality of their sleep:
Other comments:

Personal hygiene
Can your child participate in bath time:
Wash independently:
Blow nose:

Brush teeth:
Wash hair:
Other comments:

Toileting
Is your child toileting independently during the day (if so, at what age was the skill acquired):
Is your child toileting independently at night (if so, at what age was the skill acquired):
Can your child wipe independently:
Do they require special equipment:
Other comments:

Dressing
Can your child remove their own clothes:
Attempt to get dressed:
Dress independently:
Put their shoes on the correct feet:
Button their clothing:
Unbutton their clothing:
Do up zippers:
Other comments:

Hobbies
What are your child's favorite activities?
Does your child ride a bike (with or without training wheels)?

Does your child play with other children on a regular basis?
Other comments:

Global functioning & behaviour
Are there any aspects of your child's behavior that concern you? (mood, level of activity, ability to concentrate, managing transitions, arrival or departure of parents, socialization with peers etc)?
Globally, how does your child function at home and at school / daycare?