OSPTI
Pediatric Therapy Questionnaire

General Information Today's Date:____________________

Child's Name:________________________________ Date of Birth:____________________

Address:____ Phone:___________________

City/State:____ Zip:____________________

Mother's Name:___________________ Phone:____________ Occupation:_______________

Father's Name:___________________ Phone:____________ Occupation:_______________

Brothers and Sisters (names and ages):

____

____

With whom does your child spend most of their time? _________________________________

Why are we seeing your child today? ____

Date of onset of concern (approximate date) ____

Prenatal and Birth History

Mother's general health during pregnancy (illness, accidents, medications, etc.)

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Length of Pregnancy:____________________ Length of Labor:________________________

General condition of baby:____

After birth, how long was the baby hospitalized?_____________________________________

Were there any unusual conditions that may have affected the pregnancy or birth?____

____

Medical History

Has the child experienced any of the following?

Seizures_____ Ear Infections_____ Ear Tubes_____ Broken bone(s)_____

Other Illnesses____

Has your child had any surgeries? What type and when?

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Describe any accidents or hospitalizations.

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Has your child had their vision checked? Any concerns?_______________________________

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Developmental History

Provide the approximate age at which the child began to do the following:

Crawl:________________ Sit:__________________ Stand:____________________

Walk:_________________ Feed Self:_____________ Dress Self:_________________

Use toilet:_____________ Use single words:_______ Combine words:_____________

Name simple objects:__________________ Use simple questions:____________________

Engage in conversation:____

Does the child have any difficulty walking, running, or participating in other activities that require small or large muscle coordination?

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Are there or have there ever been any feeding problems? If yes, please describe.

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Describe the child's response to sound (responds to all sounds, responds only to loud sounds, inconsistently responds to sounds, etc.).

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Has the child's hearing been screened or tested? If yes, what were the results?

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Educational History

Does the child currently attend school or a preschool program?_______________________

School:____ Grade:________________

Teacher(s):____

How is the child doing academically?____

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Does the child receive special services? If yes, please explain (please provide a copy of IFSP/IEP if one has been developed for your child).

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How does the child interact with peers at school (shy, aggressive, etc.)?

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Reason for therapy

What are your child's strengths?

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What would your child like to do but is unable to do well at this time?

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What are your goals for your child?

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Please list any questions or any other concerns you have regarding your child.

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