CROSS Therapy Services
faith in what we do

48 West Colt Square Fayetteville, AR 72703

PARENT/CAREGIVER QUESTIONNAIRE

Patient Name:_______________________________________ Today's Date:____________________

Name that child prefers to be called:__________________ Date of birth:____________________

Who referred you to Cross Therapy?____

HISTORY

1. Did the mother have any prenatal problems? (bleeding, anemia, fainting, accidents, illnesses, operations or other) Was labor normal/abnormal, easy/difficult?

____

____

____

2. At how many weeks was the baby born?_________________

3. What was the method of delivery? Please specify. (Vaginal, Cesarean, Breech, Hospital, Home, etc) ____

____

____

4. During labor/delivery, were there any medications given? (epidural, codeine, etc.)

____

____

5. Did your child ever stop breathing? Did he/she use suction, ventilator, or any other means to support breathing?

____

____

6. What was your child's birth weight/length? ____________lbs.___________oz.__________inches

7. Did the child have to go to the NICU? If yes, why and how long?___________________________

____

Phone: 479-582-2740 Fax: 479-582-2746 www.crosstherapyservices.com

8. Has your child had any major health issues? If you answered yes to any of the health issues, please explain:____

____

____

9. Has your child ever been hospitalized? If yes, when and why?_____________________________

____

____

10. Has your child ever had surgery? If yes, when and why?________________________________

____

____

11. Was your child delayed in any of the developmental milestones? (rolling, crawling, walking,

eating, drawing, talking, etc) ____

____

____

12. Is there a history of any significant illnesses (CP, degenerative diseases, genetic disorders, bipolar, depression, anxiety, manic/depressive, attachment disorder, oppositional defiant, ADD, ADHD, autism, learning difficulties, speech delays, etc.) in the child's family? If yes, please list the illness and the
relation.____

____

____

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

____

____

14. Does your child have any allergies (medicine, foods, other)? 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 either to the allergies or the allergy medications.

____

____

15. Does your child carry an Epipen or other emergency medicines?__________________________

____

19. **Arousal Level** (Refers to our body's ability to respond to the environment appropriately)

Please check the words that you would consider applicable to your child.

Low Arousal	Normal Arousal	Overload 1	Overload 2
______"lazy"	______adaptable	______mood swings	______Shut down
______lethargic	______interactive	______escalates	______Poor or no response to pain
______apathetic	______goal directed	______"out of control"	______Under-responsive
______ depressed	______self initiating	______difficult to transition	______Doesn't respond with things like you think he/she should
______ difficult to transition	______manages transitions	______high activity level	
	______motivated		

Flight	Fright	Fight
______distractible	______whiney, tears, clingy	______frustration
______clowning	______fearfulness	______explosive
______redirecting	______reluctance to separate	______aggressive
______escape behavior	______reluctance to try new things	______resistive
______bored easily	______withdraws, hides "I can't"	______acting out "I won't, No"

20. **Sensory Defensiveness** (refers to a tendency to react negatively or with alarm to sensations that are generally considered harmless or nonirritating resulting in stress, anxiety, or maladaptive behavior)

Please check the words that you would consider applicable to your child.

_____ picky

_____ over sensitive

_____ under sensitive

_____ resists change

_____ controlling

_____ fearful

_____ fearless

_____ avoids specific sensory input (which ones?) ____

_____ seeks specific sensory input (which ones?) ____

_____ effort and control required to succeed

SCHOOL

1. What school/preschool/daycare does your child attend? In what city?______________________

____

2. What grade is he/she in?____________________

3. Does your child struggle academically? If yes, please explain:____________________________

____

____

4. Does your child receive any special services at school? (PT, OT, SLP, IEP, 504, resource, etc.)

____

____

7. 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.____

____

____

____

PLAY AND SOCIAL SKILLS

1. Does your child have a lot of friends, a few close friends, make friends easily, or is your child more of a "loner"?____

____

2. 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 loner, how many people your child is comfortable playing with at once, whether your child prefers a few close friends or a lot of acquaintances, their creative play and symbolic play.____

____

____

____

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CURRENT STATUS

1. With whom does your child currently live? Number of persons in the home? Please also list siblings and if they have any medical conditions.

Name	Age	Male/Female	Relation to Child	Medical Problems

2. Is your child currently on any medications? Please list them and complete the chart.

MEDICATION	REASON FOR TAKING	DOSAGE	HOW LONG HAS HE/SHE BEEN TAKING	BEHAVIORS/SIDE EFFECTS DUE TO MEDICATION

3. Does your child currently receive or has he/she received in the past any other therapies outside of school (OT, PT, Speech, vision therapy, psych, counseling, play therapy, biofeedback, or other)?

Place	Frequency	Start	Stop	OT	ST	PT	Other

For the next chart, please use the following scale to describe your child.

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

Behavior					
1. Compliant	1	2	3	4	5
2. Displays affection toward others	1	2	3	4	5
3. Displays aggression toward self	1	2	3	4	5
4. Displays aggression toward others	1	2	3	4	5
5. Irritable	1	2	3	4	5
6. Cries easily	1	2	3	4	5
7. Seems happy	1	2	3	4	5
8. Seems immature for age	1	2	3	4	5
9. Displays rapid mood swings	1	2	3	4	5
11. Seems dependent	1	2	3	4	5
12. “Baby talks”	1	2	3	4	5
13. Seems to need a lot of comfort and nurturing	1	2	3	4	5
14. Seems impulsive	1	2	3	4	5
15. Plays on playground equipment	1	2	3	4	5
16. Swings	1	2	3	4	5
17. Enjoys roughhouse play	1	2	3	4	5
18. Seems aware of safety concerns	1	2	3	4	5
19. Initiates eye contact	1	2	3	4	5
20. Sustains eye contact	1	2	3	4	5
21. Takes turns	1	2	3	4	5
22. Interacts with peers	1	2	3	4	5
23. Interacts with adults	1	2	3	4	5
24. Participates in conversations	1	2	3	4	5
25. Responds to verbal information in a timely manner	1	2	3	4	5

SPEECH STATUS

1. Does he/she play with children outside the immediate family?____________________________
How many times a week?____

2. When was your child's last hearing exam and what were the results: ______________________
____

3. Does he/she get frustrated in speaking situations?
____
____

3. How does your child react when he/she is not understood? Are any strategies used? (example: pointing, pictures,
etc.)____
____
____

7. How would you describe your child's communication problems at this time? (Example: poor vocabulary, difficulty staying on topic, some difficulty being understood by others,
etc.)____
____
____
____

8. Have these problems become more noticeable recently or have they been relatively stable over time?____

11. Has your child or does your child currently have any feeding/swallowing problems?
____

12. Has or is your child on an altered/restricted diet (thickened liquids, mechanical soft, pureed food, etc.) If so, please describe.
____
____

14. If your child is nonverbal, please describe the frequency and types of vocalizations your child uses and how your child communicates or any other alternative communication devices. Give examples.
____
____

SELF CARE/DAILY ROUTINES

For the next chart, please rate your child's level of independence for each of the following tasks **and describe** his/her behavior during the tasks.
Key:

1- total assist 2-Max. assist 3- Mod. assist 4- Min. assist
5- Set-up 6- Modified independence 7- Complete independence

Task	Independence	Behavior/Ability
Teeth brushing		
Hair brushing		
Hand washing		
Toileting		
Bathing		
Snaps		
Buttons		
Zippers		
Tying Shoes		
Feeding		
Dressing		

1. Please describe a typical mealtime with your child. Include where, what, and how your child eats, his/her typical appetite, the number of meals & snacks your child eats each day, and his/her behavior during meal times. Is your child a picky eater?

____

____

____

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

____

____

____

3. Describe your child's attention and any strategies that your child uses to help himself/herself sustain focused attention.______________________________

____

____

PARENTAL CONCERNS

1. What do you see as your child's strengths?

____

____

____

2. What are your concerns about your child?

____

____

____

____

3. What have you been told by doctors, teachers, and/or others about your child's abilities and needs?

____

____

____

____

4. What do you hope will be gained by having your child seen at this clinic?

____

____

____

____

THIS FORM WAS COMPLETED BY:______________________________________
Print Parent/Guardian name

RELATIONSHIP TO CHILD:______________________________________

PARENT/GUARDIAN SIGNATURE:______________________________________