OCCUPATIONAL THERAPY QUESTIONNAIRE – KEY SCHOOL

A. GENERAL

Date of Evaluation: _____

Child's Full Name: _____

Date of Birth: _____

Age: _____

Father's Name and Surname: _____

Mother's Name and Surname: _____

Home Language: _____

Home Address: _____

Postal Address: _____

Telephone Number: Home: _____

Cell / Work: Father: _____

Cell / Work: Mother: _____

Email Address of Parents: _____

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Medical Aid Details:

Name of Main Member: _____

Medical Aid Name: _____

Medical Aid Number: _____

General Practitioner: _____

GP Telephone Number: _____

Specialist Doctor (Name and speciality)_____

Specialist Contact Number : _____

Diagnosis (if any): _____

Medication: _____

Reason for referral / concerns: _____

_____

_____

B. BIRTH HISTORY

Please supply more details where necessary.

PREGNANCY

1. Mother's age when child was born: _____
2. Was the pregnancy healthy? _____
3. Did the mother have German measles or other viral infections? _____

_____

If so, at which stage in the pregnancy? _____

4. Was there Rh-incompatibility? _____
5. Were any of the following symptoms noted?

Threatening miscarriage: _____

Excessive swelling: _____

Kidney Infection: _____

High blood pressure: _____

Low blood pressure: _____

Nausea and vomiting: _____

Fainting: _____

6. Was the mother put on any medication? _____

_____

7. Was the pregnancy planed? _____

8. Emotional state of the mother during the pregnancy: _____

BIRTH

1. Was the child born in a hospital? _____

2. Birth weight: _____

3. Duration of pregnancy:

Full term: _____

Premature: _____ How many weeks? _____

Overdue: _____ How many weeks? _____

4. Was the labour prolonged? _____

Was the labour very short? _____

Was the labour average length? _____

5. Was it a normal birth? _____

Breech delivery: _____

Elective caesarean section: _____

Emergency Caesarean section: _____

Induction: _____

Epidural: _____

6. Were instruments used e.g. forceps or suction? _____

7. Was the baby blue at birth? _____

8. Was s/he put in an incubator? _____

9. Did s/he develop jaundice? _____

10. Was s/he treated with phototherapy? _____

11. Did the baby have sucking / swallowing problems? _____

_____

12. Was s/he breastfed and for how long? _____

13. Did s/he have difficulties sleeping? _____

Other aspects of importance not mentioned above: _____

_____

_____

C. MEDICAL

1. Is the child healthy at present? _____

2. Does s/he have frequent ear/throat infections? _____

3. Has the child had any operations? _____

What was the operation and when? _____

_____

4. Does the child suffer from any chronic illness or allergies? _____

_____

5. Does the child have to take medication on a regular basis? _____

If so, which medication: _____

6. Has his/her hearing been formally tested? _____

When and what was the result? _____

7. Has his/her vision been formally tested? _____

When and what was the result? _____

8. Name any serious accidents the child has been involved in: _____

_____

9. Which children's diseases has the child had and when? _____

_____

10. Has the child had an epileptic fit or convulsions associated with high fever and when? _____

_____

11. Has the child been hospitalized? _____

Reason, length of time and at what age: _____

Other important factors not mentioned e.g. Neurological assessments: _____

_____

_____

D. DEVELOPMENT

1. At what age did the child?

   Sit up: _____

   Crawl: _____

   Did s/he crawl in the normal way? _____

   Walk: _____

   Say his/her first words: _____ First words: _____

   Say short sentences: _____ Sentence: _____

2. Was the child put in a walking ring? _____

   If so, for how long? _____

3. At what age did the child feed independently with a spoon? _____

4. At what age was the child toilet trained? _____

If unsure of the exact age, do you feel any of the above was normal, fast or slow?

_____

E. FAMILY

1. Other children in the family? _____

   Name: _____ Age: _____

   Name: _____ Age: _____

   Name: _____ Age: _____

2. Who does the child live with (during the week/on weekends)? _____

_____

3. Father's Occupation: _____

4. Mother's Occupation: _____

5. Does anyone in the family have a learning problem? _____

   Please give details: _____

6. Does anyone in the family have emotional problems? _____

   Please give details: _____

_____

6. Has either parent been divorced? _____

   Which one? _____

   Have they remarried? _____

7. Does anyone in the family suffer from an allergy or chronic illness? _____

   Describe: _____

_____

F. SCHOLASTIC

1. Has the child attended any other crèche, playgroup, or nursery school? _____

   For how long? _____

2. How long has the child been at The Key School?_____

3. Has s/he had any previous therapeutic intervention (OT, Physio, Speech therapy)? ____

   OT – name and contact number: _____

   - length of and age at intervention? _____

   SLT – name and contact number: _____

   - length of and age at intervention? _____

   Physio – name and contact number: _____

   - length of and age at intervention? _____

   Other – name and contact number: _____

   - length of and age at intervention? _____

4. What is the quality of your child's?

Fine motor skills: _____

Gross motor skills: _____

Concentration: _____

Memory: _____

G. BEHAVIOUR

1. Does s/he get on well with siblings? _____

_____

2. Does s/he interact with peers or adults? If so what is the quality of the interaction? ___

_____

3. Are there any emotional or behavioural problems at home? _____

_____

H. INDEPENDANCE

1. Is the child able to dress him/herself? _____

Buttons: _____

Zips: _____

Shoelaces: _____

Buckles: _____

Did the child learn to do this easily? _____

2. Does the child eat with a spoon, knife, fork? _____

3. Is s/he a messy or fussy eater? _____

4. How does s/he respond to or assist with ?

Bathing: _____

Washing hair: _____

Hair care: _____

Brushing teeth: _____

I. PLAY AND OTHER ACTIVITIES

1. Which play activities does your child enjoy most? _____

_____

3. Is s/he able to ride a bicycle (push bike, balance bike or pedal bike), since when? _____

_____

4. Is s/he dextrous when climbing jungle gyms / trees? _____

5. Does s/he have a specific play interest/favourite toy ? _____

_____

6. Is s/he fond of cutting, drawing, colouring? _____

Are there any other details in connection with your child which you wish to bring to my attention? _____

_____

_____

_____

_____

SIGNATURE OF PARENT/GUARDIAN: _____

SIGNATURE OF THERAPIST: _____

DATE: _____