

OCCUPATIONAL THERAPY QUESTIONNAIRE

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: _____

Medical Aid Details:

Name of Main Member: _____

Medical Aid Name: _____

Medical Aid Number: _____

General Practitioner: _____

GP Telephone Number: _____

School: _____

Grade: _____

Teacher's Name and Contact Number: _____

Who referred you to this practice? _____

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 planned? _____

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. Did the child attend a crèche, playgroup, or stay with a day-mother? _____

For how long? _____

2. Did the child attend Nursery School, which one? _____

For how long? _____

3. How old was the child when s/he started Grade 1? _____

4. Was s/he tested for school readiness or have an IQ Test? _____

By whom and when? _____

What the result or recommendation? _____

5. Has the child failed a Grade? Which one and when? _____

6. Has your child been in a Special Needs class and for how long? _____

7. Has your child received Occupational Therapy, Speech Therapy or Remedial Tuition before? _____

By whom, contact details and for how long? _____

8. Does your child have any scholastic problems at present? _____

Please specify: _____

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

Handwriting: _____

Concentration: _____

Memory: _____

G. BEHAVIOUR

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

2. Does s/he make friends easily and appear socially well adjusted? _____

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 eater? _____

4. Does s/he bath independently, with/without supervision? _____

Washing hair: _____

Hair care: _____

Brushing teeth: _____

5. Do you feel s/he is a clingy child or emotionally dependent? _____

I. PLAY AND OTHER ACTIVITIES

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

2. Does s/he participate in sport or extra mural activities? _____

Which? _____

3. Is s/he able to ride a bicycle, since when? _____

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

5. Does s/he have a specific hobby? _____

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

Is s/he good at this? _____

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: _____