The Center for Pediatric Therapies

Therapy Evaluation Questionnaire

Child's Name: ______________________ Today's Date: ______________
Date of Birth: ______________________ School/Grade: ______________

Father's Name: ______________________ Emergency Contact: ______________
Mother's Name: ______________________ Home Phone: ______________

Please list ages & relationships of persons living in the home with the child:
Parents: ______________________
Siblings: ______________________
Other: ______________________

Diagnoses: ______________________
Referring Physician: ______________________
Reason for Referral: ______________________

Background Information:
☐ Full Term Pregnancy ☐ No Pregnancy or Birth Complications
Gestational Weeks: ______________ Birth Weight: ______________
Complications During Pregnancy/Delivery: ______________________

Medications Used During Pregnancy: ______________________

☐ Premature Birth Number of Weeks Premature: ______________
☐ Oxygen Length of Time: ______________
☐ Feeding Tube Length of Time: ______________
☐ NICU Length of Time: ______________

Newborn Medications: ______________________
Newborn Surgeries: ______________________

Childhood Hospitalizations and/or Surgeries:
Age: _______ Reason: ______________________
Age: _______ Reason: ______________________
Age: _______ Reason: ______________________
Age: _______ Reason: ______________________

Medications:
Past (please list ages): ______________________
Current: ______________________

Therapies:
Past (please list ages): ______________________
Current: ______________________

Allergies: ______________________

On a scale of 1 to 4, how well does the child function in the following areas?
1 = Completely dependent on others. Needs lots of help or cues.
4 = Completely independent. No difficulties in this area.

Dressing Upper Body	☐1	☐2	☐3	☐4	☐N/A
Dressing Lower Body	☐1	☐2	☐3	☐4	☐N/A
Toileting	☐1	☐2	☐3	☐4	☐N/A
Eating (breast or bottle)	☐1	☐2	☐3	☐4	☐N/A
Eating (soft foods off spoon)	☐1	☐2	☐3	☐4	☐N/A
Eating (with fingers)	☐1	☐2	☐3	☐4	☐N/A
Eating (with utensils)	☐1	☐2	☐3	☐4	☐N/A
Playing with familiar peers	☐1	☐2	☐3	☐4	☐N/A
Playing with unfamiliar peers	☐1	☐2	☐3	☐4	☐N/A
Handwriting	☐1	☐2	☐3	☐4	☐N/A
Frustration tolerance	☐1	☐2	☐3	☐4	☐N/A
Sleeping routine	☐1	☐2	☐3	☐4	☐N/A
Grooming (hair)	☐1	☐2	☐3	☐4	☐N/A
Grooming (bathing)	☐1	☐2	☐3	☐4	☐N/A
Grooming (teeth)	☐1	☐2	☐3	☐4	☐N/A
Maintaining attention to tasks	☐1	☐2	☐3	☐4	☐N/A
Entertaining self	☐1	☐2	☐3	☐4	☐N/A
Hand/eye coordination	☐1	☐2	☐3	☐4	☐N/A
Balance	☐1	☐2	☐3	☐4	☐N/A
Following verbal directions	☐1	☐2	☐3	☐4	☐N/A
Safety awareness	☐1	☐2	☐3	☐4	☐N/A
Mobility	☐Rolling	☐Sitting	☐Crawling	☐Standing	☐Walking

Please list your child's strengths:

Please list your child's weaknesses:

What are your goals for therapy?

Please list specifically any equipment your child uses:

Please let us know your child's favorite things:
Food: ______________________ Snack: ______________________
Drink: ______________________ Candy: ______________________
Toy: ______________________ Game: ______________________
Activity: ______________________ TV show/Movie: ______________________
Other Favorites: ____

Additional Information:

With whom does the child spend most of their time?

How does the child usually communicate (gestures, single words, short phrases, sentences)?

At what age did your child start babbling?

At what age did your child begin to use gestural communication (e.g. wave goodbye)?

At what age did your child produce his or her first word?

At what age did your child start combining words into 2-word phrases?

Are there speech, language, or hearing problems in your family? If yes, please describe.

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

If enrolled for special education services, has an Individualized Education Plan (IEP) been developed? If yes, please describe most important goals.

Please include any other information you think may be helpful on the back.