# Cowtown Pediatrix Clinic
# Occupational Therapy Intake Questionnaire

Child's name: _____Birth Date:_____Age:____
Grade/School:_____

Lives with: _____ Siblings?_____

Medical Diagnosis: ☐None ☐ASD ☐ADHD ☒CP ☐Genetic Disorder ☐Learning Differences: explain_____☐Other_____

Past medical history: _____

Allergies? _____

Medications:☐none List:_____

Pregnancy/Birth complications?

_____

Developmental Milestones met on time? _____

Is your child in good health overall?

_____

Is your child verbal or non-verbal? Circle one. Speech concerns? _____

Does your child comprehend verbal directions as well as other children? ☐Yes ☐No

**Functional Issues**

1. What are your primary concerns and the primary reasons you are coming here for OT services?_____
   _____
   _____
   _____

2. Are you concerned about your child's judgement for safety? If yes, please describe:_____
   _____
3. On the scale below, circle a number to describe your level of concern for your child:
   Mild: 0 1 2 Moderate: 3 4 5 6 Severe: 7 8 9 10
4. How often do you experience these difficulties with your child? ☐Daily ☐Weekly

5. Describe your child @ present: (**check all that apply**). Please do not skip.

**SOCIAL-EMOTIONAL**:

☐easy going

☐accepts "no" for an answer
☐transitions poorly
☐mostly quiet
☐stubborn/resistant to change
☐usually happy
☐temper tantrums

: ☐rarely, ☐daily, ☐ weekly
☐tantrums triggered by:_____
____
☐tantrums soothed by:_____
_____
☐disruptive behaviors (scale 1-10)_____

☐difficulty separating from caregiver
☐difficulty participating in "non-preferred task
☐big emotions
☐anxious
☐easily frustrated
☐gives up instead of trying.

**COGNITIVE**:

☒poor attention span
☐impulsive
☐doesn't listen
☐normal attention span compared to peers
☐sudden outbursts

☐does better 1:1
☐interrupts frequently
☐difficulty paying attention during circle/lecture time

☐follows simple directions
☐follows multi-step directions

**PLAY**:

☐needs to be in control
☐difficulty following someone else's rules
☐can take turns ☐ plays side by side peer but does not interact

☐makes friends easily
☐difficulty sustaining friendships
☐shares well
☐poor sharing
☐changes the rules mid play

☐plays the same thing over and over again despite a variety of play options
☐struggles to play with peers.

**SENSORY**:

☐overly active

☐compulsive rituals: explain_____

☐doesn't like to get dirty

☐the messier the better
☐leans on objects
☐seeks jumping, crashing, banging
☐likes squeezes
☐compression

☐overly sensitive to everyday noises, sounds
☐fails to react to loud noises
☐ high pain tolerance
☐gets carsick easily
☐poor self-regulation/overly stimulated with movement-based activities
☐prefers to touch rather than be touched
☐uses too much force on objects
☐uses too little force on objects.

**MOTOR**:

☐motor or vocal tics/falls often
☐dislikes head inverted
☐dislikes elevator or escalators
☐poor coordination
☐avoids swings

☐clumsy
☐avoids playground equipment
☐good coordination
☐athletic
☐fatigues faster than peers

☐difficulty learning to ride a bike
☐runs well
☐can ride a bike without training wheels.

**ACADEMIC**:

☐messy handwriting
☐poor pencil grasp
☐confuses left and right
☐poor spelling
☐looses place while reading
☐adds or drops letters when writing

☐rubs eyes when reading or writing
☐squints/tilts head when writing
☐slower than peers with writing
☐frequent reversals "b/d"

☐written output is significantly behind verbal or intellectual abilities
☐difficulty sitting still
☐too heavy pencil pressure
☐too light pencil pressure.

6. Does your child have difficulty with any self-care tasks for his age? **Check all that apply**:

**Dressing**:

☐has clothing sensitivities
☐ Likes smooth textures
☐hates tags/seems
☐prefers too much clothing
☐likes tight clothing
☐likes loose clothing

☐prefers to wear nothing
☐can do fasteners
☐cannot do fasteners
☐can tie shoelaces
☐was difficult learning to tie shoes

☐difficulty completing dressing routines, gets distracted
☐struggles to get dressed without tantrums
☐requires same routine daily or can't function

**Grooming**:

☐age-appropriate assistance required
☐fears hair washing
☐hates water on face
☐hates sensation of toothbrushing
☐requires same routine or has meltdown
☐fears dentist
☐does not tolerate haircuts
☐does not tolerate nail trimming
☐auditory hypersensitivity to hair/hand dryers and or toilets flushing

**Bathing**:

☐age-appropriate assistance required
☐does not complete all steps necessary

**Toileting**:

toilet trained day and night
☐toilet trained day only
☐was easy to learn toilet training
☐delayed toilet training
☐wears diaper
☐wears pull up at night
☐has accidents despite being trained

**Sleeping**:

☐ good bedtime routine
☐good sleep regulation
☐falls asleep easily
☐has difficulty falling asleep
☐never wakes up at night
☐wakes up 1-2x/s per night
☐ wakes up 3+ times per night/can put self-back to sleep
☐cannot put self-back to sleep
☐rigid bedtime routines or can't go to sleep

**FEEDING**:

☐picky eater
☐good eater
☐gags or refuses to eat certain foods based on color, texture, or temperature
☐refuses mixed textures
☐likes soft or mushy foods
☐hates soft or mushy
☐likes hard or crunchy
☐hates crunchy
☐prefers hot
☐prefers cold
☐has less than 10 food items that he will eat

Would you like feeding addressed during therapy? ☐Yes ☐No.

7. What are your child's favorite activities /loves doing the most?

_____

8. What are your child's greatest accomplishments?

_____

9. What does your child dislike the most?
   _____
10. Does your child have difficulty with daily routines? Please describe:_____
    _____
    _____

11. Are your family's everyday activities affected by your child's current behaviors?

    ☐No ☐Yes_____

12. What do you think has caused the problem? _____
13. Approximately when did it start? _____ Is it getting better or worse?
    _____

14. Does your child prefer one hand over the other? ☐Yes ☐No Right Left

15. Current school placement? ☐Regular ed ☐Special ed/IEP ☐Gifted ☐Private ☐Public

16. Does your child like school? ☐Yes ☐No
17. Does your child struggle at school? ☐Yes ☐No
18. Has your child had services before? ☐OT ☐Speech ☐PT ☐Play Therapy ☐ABA
    Frequency & Duration:_____

19. Please list all other past testing medical/educational/psychological:_____
    _____
    _____

20. Please list all other current therapies/medical/psychological interventions:_____
    _____

Please tell us anything else you want your therapist to know about your child:_____
_____

_____
_____
_____

Thank you!!!! Your feedback is invaluable to your evaluating therapist and much appreciated!!

Person completing this questionnaire: _____

Date: _____ Parent names: _____

Email: _____Phone:_____

**Cowtown Pediatrix Clinic, LLC** www.cowtownpediatrixclinic.com office@cowtownpediatrixclinic.com817-386-5500 (o&f) 4011 Benbrook Highway,Ste C Fort Worth, TX 76116