

CHILD'S NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

**OCCUPATIONAL THERAPY (OT) QUESTIONS:**

**Does child:**

Have problems with fine motor tasks (i.e. dressing, buttons, zippers, grasping utensils/pencils, etc.)?  Y  N

*If yes, please explain:* \_\_\_\_\_

Have any sensory issues (i.e. problems with clothing tags, textures, bathing, tooth brushing, hair brushing, tantrums in stores or if "routine is not followed", etc.)?  Y  N

Seek deep pressure (throws self on ground/furniture, likes bear hugs, rough play, etc)?  Y  N

Have handwriting issues?  Y  N

Have feeding issues such as choke/gags on foods, will not eat "age-appropriate foods, doesn't like certain textures of food such as "soft/mushy" etc? *If yes, please fill out Feeding Questionnaire.*  Y  N

**FEEDING/NUTRITION:**

Has child had food allergy testing? <input type="checkbox"/> Y <input type="checkbox"/> N <i>(Please provide copy of results)</i>	Does child have any food allergies/sensitivities (i.e. lactose intolerance)? <i>If yes, to what and what is reaction?</i> <input type="checkbox"/> Y <input type="checkbox"/> N
Does child spit up more often/ more fluid than normal? <input type="checkbox"/> Y <input type="checkbox"/> N <i>If yes, explain:</i>	Has child had swallow study or testing for gastrointestinal (stomach) problems? <i>If yes, where/results:</i> <input type="checkbox"/> Y <input type="checkbox"/> N
Does child cough a lot? <input type="checkbox"/> Y <input type="checkbox"/> N <i>If yes, explain:</i>	Does child often sound congested? <input type="checkbox"/> Y <input type="checkbox"/> N <i>If yes, explain:</i>
Does child have reflux? <input type="checkbox"/> Y <input type="checkbox"/> N <i>If yes, is child medicated for reflux:</i> <input type="checkbox"/> Y <input type="checkbox"/> N	<u>Please list medication</u> <span style="float: right;"><u>initial start date:</u></span> 1. 2. 3.
Please list stage/type of baby food/formula that child is currently using <i>(describe any problems with certain textures of food)</i> 1. <span style="margin-left: 300px;">3.</span> 2. <span style="margin-left: 300px;">4.</span>	
Does child <i>(check all that apply)</i> : <input type="checkbox"/> Eat table food <span style="margin-left: 150px;"><input type="checkbox"/> Finger food</span> <input type="checkbox"/> Drink from bottle without leakage <span style="margin-left: 100px;"><input type="checkbox"/> Drink from sippy cup</span> <input type="checkbox"/> Drink from uncovered cup <span style="margin-left: 100px;"><input type="checkbox"/> Choke or gag when feeding</span> <input type="checkbox"/> Currently require tube feeding (NG, G, NJ) <span style="margin-left: 100px;"><input type="checkbox"/> Use utensils</span>	

Has the child required tube feeding in the past?  Y  N

**FAMILY CONCERNS/GOALS:**

*Please list YOUR OT concerns:*

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*Please list YOUR OT goals for the child for the next SIX months:*

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