J. Z. MANN PEDIATRIC THERAPY, INC. *ADDENDUM TO PARENT QUESTIONNAIRE (04-2013)*

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

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

FAMILY CONCERNS/GOALS:

Please list YOUR OT concerns:

_____

_____

_____

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

_____

_____

_____