

Child's Name: \_\_\_\_\_

*Nimble Kids LLC d/b/a*  
*Comprehensive Therapy Children's Center*  
Evaluation Questionnaire

What is your child's birth date?

\_\_\_\_\_

Who are your child's primary physicians, including specialist (i.e. neurologist)?

\_\_\_\_\_

Were there any complications at birth? (Please Explain)

\_\_\_\_\_

\_\_\_\_\_

Has your child had any surgeries or procedures (i.e. shunts, botox, orthopedic, ear tubes, etc. or is any scheduled? If so when?

\_\_\_\_\_

\_\_\_\_\_

Is your child on any medications? If so, what for?

\_\_\_\_\_

\_\_\_\_\_

Does your child have allergies? \_\_\_\_\_ If yes, please list allergies. \_\_\_\_\_

\_\_\_\_\_

Does your child experience seizures? If so, when was your child's last seizure?

\_\_\_\_\_

What concerns you most about your child's development?

\_\_\_\_\_

\_\_\_\_\_

Please list ages for the following or N/A if not applicable:

First Word(s) \_\_\_\_\_ Walk Without Assistance \_\_\_\_\_

Sit Up By Him/Herself \_\_\_\_\_ Stand Up Without Assistance \_\_\_\_\_

Please list any foods, sounds, objects or textures that your child dislikes.

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What toys, music, or games does your child like?

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Does your child currently attend school preschool or day care? Where?

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How many hours per day and what days does he/she attend?

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Do you or your child's teacher have any concerns with your child's performance or behavior in this setting?

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Does your child receive additional physical, occupational, or speech therapy?

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Characterize your child's behavior with other children, family members, and strangers.

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Overall my child functions:

- A. What I consider typical for his/her age most of the time
- B. Below others his/her age in some areas
- C. Below others his/her age in most areas

Please list special equipment your child uses (i.e. wheel chair, orthotics, splints, etc.)

Please check the appropriate box for assistance with the following:

	<u>Independent</u>	<u>Requires Some Assistance</u>	<u>Requires Total Assistance</u>
Toileting in Potty	_____	_____	_____
Dressing	_____	_____	_____
Feeding Self with Spoon	_____	_____	_____
Feeding Self Finger Foods	_____	_____	_____
Washing Self with Washcloth	_____	_____	_____

Does your child primarily communicate by vocalizing sounds, gesturing or pulling you to object, or using words?

Write 3 outcomes for each therapy your child receives that you want your child to be able to do. (circle N/A if not applicable)

- Speech** 1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_

- Occupational** 1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_

- Physical** 1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_