



EVALUATION QUESTIONNAIRE

Child's Name: _____ Child's Birthdate: _____

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.

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

Does your child currently attend school, preschool, or day care? If yes, where?

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

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

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

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

- 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:

	INDEPENDENT	REQUIRES SOME ASSISTANCE	REQUIRES TOTAL ASSISTANCE
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. _____
 N/A 2. _____
 3. _____
- OCCUPATIONAL** 1. _____
 N/A 2. _____
 3. _____
- PHYSICAL** 1. _____
 N/A 2. _____
 3. _____