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. ______________________________