PARENT QUESTIONNAIRE
OCCUPATIONAL THERAPY SERVICES

Please return as soon as possible.

The information you give us will help us to understand your child and to better plan for his or her visit. Not all questions may apply to your child. **Please print a copy, complete and fax or mail as soon as possible to your clinic. If you do not send ahead of time, please bring completed form with you to the evaluation.**

Date:_____

Child's Name: _____

Date of Birth:_____Gender: Male ☐ Female ☐

Medical or Developmental Diagnosis:_____

Language(s) Spoken at Home if other than English: _____

Parent(s) or Guardian(s) name(s): _____

With whom does the child live? _____

Person completing questionnaire: _____Relationship to child: _____

Phone numbers please list best contact numbers: _____

Email Address: _____

Brothers/Sisters (Include names and ages):_____

REASON FOR REFERRAL

Who referred you for this evaluation? _____

Why did they refer your child for this evaluation?_____

_____

What are your main concerns about your child?_____

_____

_____

What are your goals for therapy?_____

_____

What are your child's strengths?_____

_____

MEDICAL HISTORY

Were there any problems during your pregnancy? Yes ☐ No ☐

Were there any problems during your child's birth? Yes ☐ No ☐

Has your child had any significant illnesses, injuries, and/or hospitalizations? Yes ☐ No ☐

If yes to any of the above, please describe:_____

_____

_____

List any medications currently taken by your child: _____

_____

Does your child have any allergies? Yes ☐ No ☐

If yes, please list: _____

Is your child on a specific diet or food restrictions? Yes ☐ No ☐

If yes, please list: _____

Does your child have regular sleeping habits or good ability to fall asleep and stay asleep? Yes ☐ No ☐

If no, please describe: _____

_____

Does your child have a history of frequent ear infections? Yes ☐ No ☐ Age Started: _____

If yes, how many infections did he/she have in the past year? _____

Does your child have ear (PE) tubes? Yes ☐ No ☐

Has your child's hearing been tested? Yes ☐ No ☐

If yes, when/where: _____ Results: _____

Has your child's vision been checked? Yes ☐ No ☐

If yes, when/where: _____ Results: _____

EDUCATIONAL INFORMATION

Does your child receive early intervention services through the school district? Yes ☐ No ☐

Does your child currently attend school? Yes ☐ No ☐

Name of School/Grade: _____

Does your child have a current Individual Education Plan (IEP) or Individual Family Service Plan (IFSP)?

Yes ☐ No ☐

Daycare or other programs: _____

OTHER PROFESSIONALS

Please check if your child is currently receiving any of the following services or have in the past, and provide location:

Occupational Therapy ☐ _____

Physical Therapy ☐ _____

Speech Therapy ☐ _____

Psychology ☐ _____

Neurology ☐ _____

Gastroenterology ☐ _____

Other ☐ _____

****Please bring copies of any formal evaluations/screenings you feel would be helpful at your appointment.**

DEVELOPMENT, SELF CARE & DAILY ROUTINES

Please list approximate ages that your child accomplished major developmental milestones:

Rolling: _____ Sitting: _____ Crawling: _____

Walking: _____ Talking: _____

Does your child communicate verbally? Yes ☐ No ☐

If your child is non-verbal, describe how do they communicate with you? _____

_____

Please indicate if you have concerns in any of the following areas:

Check level of performance your child is able to complete:

Dressing Skills:

Child can independently dress self? Yes ☐ No ☐

Child can zip and button clothing? Yes ☐ No ☐

Child needs occasional assistance to dress? Yes ☐ No ☐

Child is starting to push arms through sleeves; legs through pant legs? Yes ☐ No ☐

Parent dresses child on a daily basis? Yes ☐ No ☐

Comments: _____

Feeding Skills:

Do you have concerns about your child's eating habits? Yes ☐ No ☐

Child is a very picky eater will only eat certain foods or textures? Yes ☐ No ☐

Feeding utensils:

Child uses spoons/forks at every meal? Yes ☐ No ☐

Occasionally or needs reminders to use utensils? Yes ☐ No ☐

Never uses utensils. Yes ☐ No ☐

Child eats an adequate amount of food for his/her age? Yes ☐ No ☐

Child is willing to sit at table/highchair for all meals. Yes ☐ No ☐

Comments:_____

Motor Skills:

Child appears clumsy or uncoordinated? Yes ☐ No ☐

Child has difficulties with handwriting? Yes ☐ No ☐

Child fatigues easily and has poor endurance? Yes ☐ No ☐

Child has difficulties learning new motor skills? Yes ☐ No ☐

Comments: _____

Social Interactions:

Does your child play with age appropriate toys? Yes ☐ No ☐

Does your child respond when his/her name is called? Yes ☐ No ☐

Does your child have difficulties with transitions to new activities/environments? Yes ☐ No ☐

Does your child have difficulties with changes in routine? Yes ☐ No ☐

Does your child have poor frustration tolerance? Yes ☐ No ☐

Does your child have poor safety awareness in the community? Yes ☐ No ☐

If your child is upset or angry do they have difficulties calming and coping with anger? Yes ☐ No ☐

Comments: _____

Do you have concerns about your child's ability to play with other children? Yes ☐ No ☐

Please describe: _____

Sensory Processing:

<u>Does your child have significant fear, aversion or difficulties with the following items?</u>

Washing/cutting hair Yes ☐ No ☐

Cutting finger nails Yes ☐ No ☐

Brushing teeth/oral care Yes ☐ No ☐

Loud and unexpected sounds Yes ☐ No ☐

Clothing textures/fabric Yes ☐ No ☐

Avoids swings/climbing/movement Yes ☐ No ☐

Avoids messy play/getting dirty Yes ☐ No ☐

Do any of the following statements describe your child?

Difficulties with calming down	Yes ☐	No ☐
Difficulties focusing attention	Yes ☐	No ☐
Engages in risky play activities	Yes ☐	No ☐
Prefers rough play	Yes ☐	No ☐
Child craves movement	Yes ☐	No ☐
Child is constantly moving "on the go"	Yes ☐	No ☐

Any other comments or questions you have for the therapist:_____

_____

Please return this questionnaire before your appointment to help us plan a thorough evaluation. It may be returned in person, by mail, or by fax to:

Canadian Association of Occupational Therapists
2020 Conference Workshop

Questioning White Supremacy in OT Practice and Education

Marie-Lyne Grenier, MScOT, DOT, erg. marie-lyne.grenier@mcgill.ca
Hiba Zafran, PhD, Occupational Therapist-Psychotherapist hiba.zafran@mcgill.ca

Reflexive Questions

Adapted from:
Phenix, A. (2019, August). *What is cultural safety and why it matters as you go out into practice - where everyone should start in relation with Indigenous Peoples*. Lecture given during the Lavigne-Smee Visiting Scholar Award ceremony, Montreal, Quebec.
https://www.mcgill.ca/spot/article/four-burning-questions-angie-phenix

- What assumptions does this assessment make?
- Whose interests are served by this assessment?
- Whose interests are not served by this assessment?
- Whose knowledge and values does this assessment align with?
- Can the client refuse the assessment and what will happen if the client refuses?
- Does this evaluation leave room for collaboration and partnership with the client?
- What is the status of my relationship with the client? Do I have a sense of their beliefs and values?
- What can I do to reduce the power differential between me and my client?
- What other assessment method(s) would be more appropriate? Is the assessment needed at all?