# TheraPlay at Home

## Pediatric Therapy Services

Phone: 407-790-5601 Fax: 407-602-7858 info@theraplayathome.com

## *Parent Questionnaire*

Child's Name: ___________________________ Parent/Guardian Name: ___________________________

Date of Birth: ___________________________ Relationship to Child: ___________________________

Home Phone: ___________________________ Referring Physician: ___________________________

Mobile Phone: ___________________________ Email: ___________________________

## Primary Therapy Concerns

Please describe any concerns regarding your child's abilities in the following areas: *fine motor and/or gross motor development, sensory, feeding, daily living skills, visual, movement, behavioral, and interpersonal.* Please feel free to include any other areas of concern not mentioned. This helps the therapist to create a better picture of your child's needs. Use the back of this page as needed.

## Medical History

Please briefly describe your child's relevant medical history. Please include *mother's health during pregnancy, weeks of gestation, any problems during delivery, baby's weight, any hospitalizations or surgeries, significant illnesses or accidents, history of ear infections and/or tubes, and history of upper respiratory infections.* Include approximate dates or child's age when possible.

Has your child been given any diagnoses? If so, please list & include approximate dates or child's age:

Please list any medications and reason:

Please list any additional vitamins, herbal, homeopathic, or other supplements:

TheraPlay at Home



Please list any allergies:

Please list any safety precautions:

## Developmental History

How old was your child at the following developmental milestones?

Hold head up ______________________
Roll ______________________
Sit unsupported ______________________
Stand ______________________
Walk ______________________
Run ______________________
Use single words ______________________
Combine two words ______________________
Feed self ______________________
Toilet train ______________________
Ride tricycle ______________________
Ride bicycle with training wheels ______________________
Ride bicycle without training wheels ______________________

Which of the following self-care skills has your child mastered?

- ☐ Undress
- ☐ Unfasten buttons ☐ large ☐ small
- ☐ Unfasten snaps
- ☐ Unfasten zippers on jacket
- ☐ Unzip and zip up a backpack
- ☐ Fasten buttons ☐ large ☐ small
- ☐ Fasten zippers on jacket
- ☐ Brush hair
- ☐ Wash hands ☐ with help ☐ by self
- ☐ Pour ☐ with spilling ☐ without spilling
- ☐ Dress self ☐ except for fasteners
- ☐ Tie a knot
- ☐ Tie a bow ☐ “bunny ears” ☐ traditional bow
- ☐ Use a spoon ☐ with spilling ☐ without spilling
- ☐ Use a fork
- ☐ Cut with fork & knife ☐ soft foods ☐ most foods
- ☐ Use cup ☐ with spilling ☐ without spilling
- ☐ Use straw ☐ Blow bubbles
- ☐ Brush teeth ☐ with help ☐ by self
- ☐ Make a snack

## Social History

What languages are spoken in the home? ______________________________________

What is your child’s primary language? ______________________________________

Who lives with the child? Give ages of other children.

---

---

With which does your child get along better? ☐ younger children ☐ same-aged children ☐ adults
How does your child respond to given instructions? How many step-directions can your child follow?

Does your child prefer or avoid certain texture of food? If yes, please describe.

---

---

## Educational History

Grade in school: ______ Name of school: ________________________________________

Does your child receive any other therapy in school or privately? If so, which?

---

What difficulties, if any, does your child have in school?

---

---

Please share any additional information you would like the therapist to know about your child:

---

---

---

## Sensorimotor History

Please mark the appropriate column. Items marked 'yes' may indicate difficulties with sensory processing skills.

| | Does the child: | No | Yes |
|---|---|---|---|
| | 1) Object to being touched | ___ | ___ |
| | 2) Dislike being cuddles | ___ | ___ |
| | 3) Seem irritable when held | ___ | ___ |
| | 4) Prefer to touch rather than be touched | ___ | ___ |
| **Tactile Sensation** | 5) React negatively to the feel of new clothes | ___ | ___ |
| | 6) Dislike having hair or face washed | ___ | ___ |
| | 7) Prefer certain textures of food | ___ | ___ |
| | 8) Avoid certain texture of food | ___ | ___ |
| | 9) Isolate self from other children | ___ | ___ |
| | 10) Frequently bump or push others | ___ | ___ |

| | Does the child: | No | Yes |
|---|---|---|---|
| | 1) Seem overly sensitive to sound | ___ | ___ |
| **Auditory Sensation** | 2) Miss some sounds | ___ | ___ |
| | 3) Seem confused about the direction of sound | ___ | ___ |
| | 4) Like to make loud noises | ___ | ___ |
| | 5) Have a diagnosed hearing loss | ___ | ___ |

# TheraPlay at Home



| | Does the child: | No | Yes |
|---|---|---|---|
| | 1) Explore the environment with smell | ___ | ___ |
| **Olfactory Sensation** | 2) Discriminate odors | ___ | ___ |
| | 3) React defensively to smell | ___ | ___ |
| | 4) Ignore noxious odors | ___ | ___ |

| | Does the child: | No | Yes |
|---|---|---|---|
| | 1) Have a diagnosed visual defect | ___ | ___ |
| | 2) Have difficulty eye tracking | ___ | ___ |
| | 3) Make reversals when copying | ___ | ___ |
| **Visual Sensation** | 4) Have difficulty discriminating color | ___ | ___ |
| | 5) Appear sensitive to light | ___ | ___ |
| | 6) Resist having vision occluded | ___ | ___ |
| | 7) Become excited when confronted with a variety of visual stimuli | ___ | ___ |

| | Does the child: | No | Yes |
|---|---|---|---|
| **Gustatory Sensation** | 1) Act as though all food taste the same | ___ | ___ |
| | 2) Explore by tasting | ___ | ___ |
| | 3) Dislike foods of a certain texture | ___ | ___ |

| | Does the child: | No | Yes |
|---|---|---|---|
| | 1) Dislike being tossed in the air | ___ | ___ |
| | 2) Seem fearful in space (e.g. going up and down stairs, riding a teeter-totter | ___ | ___ |
| **Vestibular Sensation** | 3) Appear clumsy, often bumping into things | ___ | ___ |
| | 4) Prefer fast moving/spinning rides | ___ | ___ |
| | 5) Avoid balance activities | ___ | ___ |

| | Does the child: | No | Yes |
|---|---|---|---|
| | 1) Have any diagnosed muscle pathology (e.g. plasticity, rigidity, flaccidity) | ___ | ___ |
| **Muscle Sensation** | 2) Seem weaker or stronger than normal | ___ | ___ |
| | 3) Frequently grasps objects too tight | ___ | ___ |
| | 4) Have a weak grasp | ___ | ___ |
| | 5) Tire easily | ___ | ___ |

| | Does the child: | No | Yes |
|---|---|---|---|
| | 1) Manipulate small objects easily | ___ | ___ |
| | 2) Seem accident prone | ___ | ___ |
| **Coordination** | 3) Eat in a sloppy manner | ___ | ___ |
| | 4) Have difficulty with pencil activities | ___ | ___ |
| | 5) Have a difficult time dressing or fastening | ___ | ___ |
| | 6) Have a consistent hand dominance | ___ | ___ |
| | 7) Neglect one side of the body or seem unaware of it | ___ | ___ |

| | Does the child: | No | Yes |
|---|---|---|---|
| | 1) Was the child slow to reach the usual | ___ | ___ |

| | | | |
|---|---|---|---|
| | milestones (e.g. sitting, walking) | | |
| **Reflex Integration and Development** | 2) Was the child irritably in infancy when held | ___ | ___ |
| | 3) Does the child have difficulty isolating head movements | ___ | ___ |
| | 4) Does the child lack adequate protective reactions when falling | ___ | ___ |