Pediatric Therapy Center

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EMPOWERING CHILDREN, FAMILIES AND OUR COMMUNITY.

Occupational Therapy Questionnaire: 18 Months or Younger

Patient Name:_____ **Date:**_____

Please answer questions as they relate to your concerns for seeking services	Yes	No	ADDITIONAL INFORMATION
My child has difficulty feeding him/herself independently.			Finger Foods – YES NO With Utensils – YES NO
My child has difficulty with drinking from a cup and/or bottle.			
My child has difficulty with chewing age appropriate table foods. (textures, colors, variety).			
My child has difficulty tolerating eating various age appropriate (table) foods. (textures, colors, variety).			
My child has difficulty tolerating activities such as diaper changes, dressing, bathing, and toothbrushing.			
My child has difficulty with transferring an item between their hands (right to left, left to right).			
My child has difficulty using both hands (clapping, pulling apart pop beads, holding an item in both hands at the same time.			
My child has difficulty with holding or maintain grasp on a toy or item.			
My child is unable to place objects into a container. (puzzle, shape sorter)			
My child is unable to pick up small items using a pincer grasp (only thumb and index finger).			
I have concerns about my child's attention and/or interest in toys.			
My child has difficulty tolerating different clothes (long sleeves, jeans, socks, shoes)			
My child has frequent temper tantrums (compared to same aged peers)			
My child has difficulty with falling asleep/ sleeping through the night.			
My child does not imitate my facial expressions/ movements. (smile, stick tongue out)			
My child is unable to crawl (older than 9 months)			
My child is unable to sit independently.			