Pediatric Therapy Center

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EMPOWERING CHILDREN, FAMILIES AND OUR COMMUNITY.

Occupational Therapy Questionnaire

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 an open cup.			
My child currently has difficulty with being toilet trained.			Circle all that apply: Bladder Bowel Overnight
My child has difficulty dressing/undressing (shirt, pants, shoes, coat, backpack).			
My child has difficulty with managing fasteners (zippers, snaps, buttons, shoe tying).			
My child has difficulty with fine motor skills (coloring, cutting, writing).			
My child has difficulty with using a dominant/preferred hand for eating/writing/cutting.			Circle one: RIGHT LEFT INCONSISTENT
My child has difficulty with activities such as getting dressed, brushing teeth, bath, clipping nails, and combing hair.			
My child has difficulty sitting and focusing on a task for 5 to 10 minutes (NOT including TV, computer, video games, i-pad, etc).			
My child has difficulty following simple 1 and 2 step instructions.			
My child has difficulty at school.			
I have concerns about my child's sensory processing.			
My child has difficulty with eating age appropriate foods. (textures, colors, variety).			
I have concerns about my child's vision in relation to handwriting (legibility, copying from the board).			
My child has difficulty calming after tantrums/emotional outbursts.			
My child has difficulty with falling asleep/ sleeping through the night.			
My child has difficulty with complex motor tasks (riding a bike, team sports, tying shoes, etc…).			