ELLEN YACK AND ASSOCIATES
PAEDIATRIC OCCUPATIONAL THERAPY SERVICES

PARENT QUESTIONNAIRE

Child's Name: _____ Date of Birth:_____
Address: _____

Home Phone No.: _____

Parent's Names: _____

Occupation: (Parent 1) _____ (Parent 2)_____

Business Phone No.: (Parent 1) _____ (Parent 2) _____

Family Physician/Paediatrician: _____

Brothers/Sisters' Names and Ages:
_____

Preferred Hand (hand used for writing and feeding)
Child ___ Parent 1 ____ Parent 2 ___ Brothers/Sisters _____

SCHOOL INFORMATION

Name of School: _____ Grade: _____

Type of Class:
_____

Name of teacher(s):
_____

Problem Areas (Gym, Reading, Math, Behaviour, etc.):

_____

Is child receiving any special assistance in school? _ Yes _ No
If yes, please explain:

_____

DEVELOPMENTAL HISTORY

PRENATAL ~ BIRTH

Any unusual conditions or difficulties?

- Pregnancy
  _No _Yes
  If yes, please explain:

_____

- Delivery _Yes _No
  If yes, please explain:

_____

- Birth Weight: _____ _Full Term _Premature _Late

MILESTONES

	Age (Approximate)	Note any difficulty
Sitting		
Crawling		
Walking		
Toilet Training		

Was child a good feeder? _Yes _No
If no, please explain:

_____

Did child stumble and fall frequently? _Yes _No
If yes, please explain:

_____

What type of activity did child prefer as an infant or toddler (i.e., active vs. quiet play):

_____

SPEECH DEVELOPMENT

When child spoke: Age _____ Early Words: _____ Sentences: ___
_____
Is speech difficult to understand?
If yes, please explain:
_____
Does child have difficulty pronouncing particular letters/sounds?
If yes, please explain:
_____
Does child remember and follow directions well? _Yes _No
If no, please explain:
_____

MEDICAL HISTORY

Does child have history of:

- Seizures: _Yes _No Type: _____ Medication: _____
- Allergies: _Yes _No To What: _____ Medication: _____
- Ear Infection: _Yes _No · Tubes: _Yes _No
- Other Medical Conditions or Medications:

_____
Has child had vision test?
Result: _____
Has child had hearing test?
Result: _____
Has child had any accidents, injuries, or/and surgery?
Please explain: _____

Has child ever been assessed by:

Speech Therapy _Yes _No
Date: _____ Who: _____

Neurologist _Yes _No
Date: _____ Who:_____

Psychiatrist _Yes _No
Date: _____ Who:_____

Psychologist _Yes _No
Date: _____ Who: _____

Audiologist _Yes _No
Date: _____ Who: _____

Other:

ACTIVITIES OF DAILY LIVING

Which activities can child perform?

	Independently	Requires Assistance	Dependent
• Feeding	_____	_____	_____
• Washing	_____	_____	_____
• Dressing	_____	_____	_____
• Buttons/Zippers	_____	_____	_____
• Shoe Laces	_____	_____	_____
• Toileting	_____	_____	_____
• Bed-Making	_____	_____	_____
• Tidying Room	_____	_____	_____
• Kitchen Chores	_____	_____	_____

SLEEP PATTERNS

Does your child fall asleep easily? __ Yes __ No
Comments:_____
_____

Does your child sleep through the night? __ Yes __ No
Comments:_____
_____

Does your child have a specific bed-time routine? __ Yes __ No
Comments:_____
_____

Does your child easily wake up in the morning? __ Yes __ No
Comments:_____
_____

SOCIAL HISTORY & BEHAVIOUR

How would you describe child's behaviour?

_Normal _Quiet _Inattentive _Over-active _Disorganized
_Impulsive _Aggressive _Lack of self-confidence
_Wants sameness and routine _Craving attention
_Angry _Shy

Comments _____
_____

Does child have any behaviour problems at school? _Yes _No
If yes, please explain:
_____

Do you find child difficult to handle at home? _Yes _No
If yes, please explain:
_____

Does child get along with his/her brothers and sisters? _Yes _No
If no, please explain:
_____

Does child have trouble making friends? _Yes _No
If yes, please explain:
_____

Does child have any fears? _Yes _No
If yes, please explain:
_____

Is child involved in any lessons/groups (e.g., swimming)? _Yes _No

_____

What are child's favorite activities, sports, hobbies, interests?

_____

GENERAL COMMENTS

Please explain your main concerns:

_____

_____

_____

What are your expectations of this program?

_____

_____

Thank you for completing this questionnaire. The information you provided will assist in our evaluation of your child.