



Date: _____

OCCUPATIONAL/SPEECH THERAPY REFERRAL QUESTIONNAIRE

GENERAL INFORMATION

Child's Name: _____ Date of Birth: _____

Parents/Guardians: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Cell Phone: _____

Father's Employer: _____ Phone: _____

Mother's Employer: _____ Phone: _____

Names/age of Siblings. Please include any important information about siblings that would be helpful:

Family Structure: Please tell us any important regarding your opinion of your current family relationship and living circumstances. Please include child's relationship with parents, siblings, and other family members. Also, please include marital status of parents and if there are any step-parents or siblings involved.

Child's Physician: (Name, Clinic & Location, phone)

Available therapy times:

REFERRAL INFORMATION AND CONCERNS

Who referred you and your child to *Therapy for Me!* ? _____

What are the reasons for referral? _____

Does your child have a medical diagnosis? _____ If so, what is the diagnosis? _____
Where was your child's diagnostic evaluation completed? _____
When was the evaluation completed? _____

What are your major concerns regarding your child? Be as specific as possible. _____

Please list differing opinions of family members involved with the child regarding the child's primary concerns and problem areas. Please also include how specific concerns are currently handled. _____

SCHOOL INFORMATION

What school does your child attend? _____

School Address: _____

School Phone Number: _____

Teacher's Name: _____ Grade: _____

What specific concerns has your child's teacher noted within the classroom and how are these issues currently addressed? _____

What type of classroom is your child in (Regular Ed, Special Ed, Montessori, etc)? _____

Does your child have an IEP? _____ What types of special services does he/she receive? _____

Case Manager: _____

Occupational Therapist: _____

Speech/Language Pathologist: _____

(Optional) Other Contact: _____

MEDICAL INFORMATION

Please describe you child’s birth history. Include weeks gestation, vaginal/caesarean section and any complications during pregnancy, birth, or infancy. If adopted, please indicate and list any known pregnancy or birth history.

Please list any major illnesses, injuries, or surgeries your child has experienced and dates if known.

List any medications or supplements your child is currently receiving and frequency of dosages:

Are there any medical precautions the therapist should be aware of when working with your child?

Has your child had a vision test? ___yes ___no If yes, when? _____

Where? _____

Results/Recommendations: _____

Has your child has a hearing test? ___yes ___no If yes, when? _____

Where? _____

Results/Recommendations: _____

Does your child have any assistive devices? Check all that apply.

Glasses Wheelchair AFO's Orthotics
 Hearing Aids Other: _____

Does your child have a history of ear infections? If yes, please describe frequency of occurrence and method of treatment. _____

Does your child have any allergies? If yes, please list what your child is allergic to and how these allergies are treated.

Has your child had outpatient speech/language or occupational therapy in the past? If yes, please outline below:

Dates (Start – End)	Location	General Goal Areas	Reason for Discharge

DEVELOPMENTAL HISTORY

Please list approximate ages your child met the following developmental milestones:

Rolled Over		Coo	
Sat Alone		Babble	
Crawled		Imitate Sounds/Words	
Walked		Respond to “no-no”	
		Said 1 st word	
Play Pattycake/Peek-a-boo		Put 2-3 word together	
Alternate turns		Spoke in sentences	
Play appropriately with toys		Began asking questions	

Did your child demonstrate the following behaviors in infancy or early childhood:

Have feeding difficulties? yes no If yes, please describe: _____

Have sleeping problems? ____yes ____no If yes, please describe: _____

Have colic? ____yes ____no If yes, for how long? _____

Prefer certain positions as an infant? ____yes ____no If yes, describe: _____

Dislike lying on stomach? ____yes ____no Dislike lying on back? ____yes ____no

Enjoy bouncing? ____yes ____no Calmed by car rides or swings? ____yes ____no

Become nauseated by car rides or swings? ____yes ____no

Tend to be compliant? ____yes ____no Go through a "terrible twos"? ____yes ____no

COMMUNICATION SKILLS

Does your child have frequent interactions with other children? (i.e. playing with siblings, attending daycare, etc.)? If so, please describe: _____

Does/did your child make gestures (i.e. waves bye-bye, imitates others clapping, bangs on objects to get your attention, points to reference objects, dance to music, blows a kiss, nods yes/no, makes funny faces to get a laugh...etc.)

Please provide any additional information here such as emotional regulation, joint attention, social interaction, etc:

Please indicate the frequency your child does each of the tasks below:

FUNCTIONAL COMMUNICATION	Frequently Observed	Occasionally Observed	Not Observed
Attempts to say words			
Understands what is said to him/her... <ul style="list-style-type: none"> • a few words (i.e. body parts or identify pictures in a book) • simple directions • many words and phrases • almost everything I say 			
Communicates wants and needs to others by speaking			
Communicates wants and needs to others without speaking (i.e. using gestures, facial expressions, communication device, etc.)			
Communicates successfully with peers			
Speech can be understood by unfamiliar listeners			
SPEECH ACTS AND COMMUNICATION FUNCTIONS	Frequently Observed	Occasionally Observed	Not Observed
Labels things or actions			
Asks for things or actions			
Describes things or actions			
Asks for information			
Gives information			
Makes requests			
Makes promises			
Agrees			
Threatens or warns			
Apologizes			
Protests, argues, or disagrees			
Show humor, teases			
Uses greetings			
DISCOURSE SKILLS	Frequently Observed	Occasionally Observed	Not Observed
Starts a conversation			
Shows listening behavior			
Responds with appropriate content			
Interrupts appropriately			
Stays on topic			
Changes topic appropriately			
Appropriately ends a conversation			
Recognizes listener's viewpoint			
Demonstrates topic relevancy			
Uses appropriate response length			

How does your child let you know what he or she wants? (Check all that apply.)

- | | |
|-----------------------------------|--|
| _____ cries | _____ uses few words |
| _____ points | _____ says many word, one at a time |
| _____ uses gestures | _____ uses two or three word sentences |
| _____ makes a few sounds | _____ uses long sentences |
| _____ makes many different sounds | _____ asks questions |
| _____ indicates "yes" or "no" | |

Is your child using spoken words to communicate? _____ If not, have they developed an alternative communication systems (i.e. gestures, signs, PECS, AAC device, etc.)? _____

Can people in your family understand your child's speech? _____

Can people *outside* of your family understand your child's speech? _____

Is your child aware of others difficulty understanding him/her? _____

Does your child appear frustrated if he/she is not understood? _____ If so, what do they do to show their frustration?

Please provide any additional information here: _____

FEEDING

Do you have concerns about your child's eating/feeding skills? _____ no (Skip to Activities of Daily Living section)
_____ yes (Please complete the following questions)

Does your child have more than 10 foods in his/her diet? _____ yes _____ no If no, what foods does your child prefer? _____

Does your child have a limited variety of textures in his/her diet (ie. no purees, no crunchy foods, temperature sensitivity, cooked verses raw etc)?

Does your child's diet include fruits and vegetables? _____ yes _____ no If yes, please list items: _____

Does your child's diet include a variety of protein? ____ yes ____ no If yes, please list items: _____

Does your child drink from a *bottle, sippy cup, straw, or open cup*? _____

Briefly describe mealtime in your home: _____

Additional Comments (regarding feeding):

ACTIVITIES OF DAILY LIVING

Please describe your child's skills and behaviors for each of the following:

Dressing Skills (level of independence/amount of assistance needed; type of clothing your child wears; how long it takes to get dressed; behavior during dressing; etc.): _____

Hygiene (bathing skills; ability to wash hands; wash face; brush hair; brush teeth; nail cutting; behavior and tolerance of these): _____

Toileting (potty trained; level of independence with peri care; etc.): _____

Transitions (how your child adapts to change between people or environments; need for preparation regarding change in routine or schedule; need for rituals, routines or control, etc.): _____

Attention/Visual Attention (ability to sustain visual attention; what typically engages your child's attention; how distractible is your child; length of time your child can attend to a preferred, non-preferred, or new activity; etc.):

Intensity Level/Mood (level of energy for a particular activity; emotional or aggressive behaviors to touch, movement sensations, or play choices; sense of humor; any mood swings; emotions related to specific situations; facial affect; etc)

Household Responsibilities: What jobs/tasks does your child complete at home? Please list and explain, if needed.

Play Skills (ability to share toys, engage with familiar and novel toys; overall play exploration; turn taking ability; ages of people he/she chooses to play with; number of people your child is comfortable playing with; is your child a leader, follower or a loner; etc): _____

- What type of toys/play does your child enjoy?

- How long can your child engage in a play-based activity independently and with adult support?

- How do you engage in play with your child? (Roughhousing, pretend play, electronics, direct play, structured/unstructured, etc).

- What do you like to do with your child? What activities does your family like to do together?

Exploration (reaction to new environments, unfamiliar people, places, foods, procedures, etc): _____

Motor Skills (how coordinated is your child with gross motor play such as running, kicking, catching, using both sides of his/her body together; how do you perceive your child's fine motor ability, etc): _____

OTHER INFORMATION

What community activities does your son/daughter participate in? _____

Is there any other information that you feel is important for us to know? _____
