LA SPEECH PATHOLOGY SERVICES, INC.
laspeechguy@gmail.com | Ph: (310) 384-5317 | Fax: (310) 943-3333
5280 E Beverly Blvd Suite C #106, Los Angeles, CA 90022
www.laspeechpathologyservices.com

PARENT QUESTIONNAIRE / OCCUPATIONAL THERAPY

PATIENT CONTACT INFORMATION			
Last Name	**First Name**	**D.O.B.** / /	**Sex** Male / Female
Home Address	**City / State**	**Zip Code**	**Home Phone**
PARENT / GAURDIAN INFORMATION			
Mother's Last Name	**First**	**Father's Last Name**	**First**
Marital Status ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			
Employer Name			
Work Address	**City / State**	**Zip Code**	**Work Phone**
REFERRING PHYSICIAN INFORMATION			
Physician Last Name	**First**	**Address**	**Telephone**
Do you have a prescription? Yes / No If yes, specify:		**Tax ID#**	
REASON FOR ASSESSMENT			
DIAGNOSIS Has your child ever received PT, OT OR SLP? Yes / No. If yes, when and where?			
PHYSICAL Is your child having difficulty rolling, sitting or walking? Yes / No Does your child have balance and coordination? Yes / No			
OCCUPATIONAL Do you have concerns with your child's: Eating skills? _______________ Grooming/Hygiene?____________________ Eye-Hand Coordination?______________Handwriting?_______________ Dressing skills?_______________________ Does your child play with toys appropriate for his/her age?____			

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COMPLICATIONS/HEALTH PROBLEMS DURING PREGNANCY

☐ Diabetes ☐ Measles ☐ Toxemia ☐ Premature labor ☐ Strep ☐ Respiratory

☐ Other ____

Complications during labor/delivery:
☐ Cesarean Section ☐ Emergency ☐ Forceps ☐ Vacuum ☐ Other ____________________________________

Describe child's condition at/or immediately after birth:
☐ Premature, if yes, Gestational Age______ ☐ Apgars ☐ NICU ☐ Other _____________________________
☐ Ventilator, if yes, How Long? _________ ☐ Jaundice ☐ Heart Problems ☐ Poor Suck

Small for gestational age ___________ Large for gestational age ___________

Known diagnosis (e.g. Down's Syndrome) ____

Other medical complications____

CHILD'S MEDICAL HISTORY

☐ Measles ☐ Mumps ☐ Pneumonia ☐ Chicken Pox ☐ Bronchitis ☐ BPD

☐ Reflux ☐ Allergies ☐ Head Injuries ☐ Tonsilitis ☐ Other_________________________________

☐ Ear Infections, frequency ____________________ Last Ear Infection *mm/dd/yyyy*_________________________

Treatment Method ____

Has your child ever been hospitalized? If yes, list dates:

From:	To:
___________________________	___________________________
___________________________	___________________________
___________________________	___________________________

Check Yes/No to the corresponding question on the right-hand side:

☐ Yes ☐ No 1. Does your child have asthma, hay fever, eczema, or rashes? If yes, please check and comment if necessary ____

☐ Yes ☐ No 2. Is your child allergic to bananas, avocados, chestnuts, nuts, or kiwi fruit?

☐ Yes ☐ No 3. Is your child allergic to potatoes, milk, peaches, tomatoes, papaya, or passion fruit?

☐ Yes ☐ No 4. Is your child allergic to any food? If yes, please state:
____

☐ Yes ☐ No 5. Is your child allergic to any incense, essential oils, scents lotions or candles?

☐ Yes ☐ No 6. Is your child on any special diet? If yes, please describe:

List any surgery performed:
☐ Ear Tubes, if yes, still in place?________ ☐ Central Line ☐ Sinal Infusions ☐ G-Tube

☐ Heart Repair ☐ Trach ☐ Shunt ☐ Toxillectomy ☐ Appendectomy ☐ Other ___________________

Tests performed:
☐ MRI ☐ CT Scan ☐ Genetic Testing ☐ X-Rays ☐ Other ___________________

Please list current medications:

____

____

CHILD'S DEVELOPMENT HISTORY

DEVELOPMENT MOTOR MILESTONES

Please list age child accomplished the following milestones:

Lift head while on tummy	Rolled over	Sat without support	Crawled
Stood alone	Walked alone	Dressed/undressed self	Button/zip clothes
Started solid food	Held cup	Used fork	Drank from sippy cup
Open cup	Dry during day	Dry during night	Gain bowel control
Hand preference left	Hand preference right		

Does your child have any bladder or bowel difficulties? ☐ Yes ☐ No

Please describe: ____

SPEECH AND LANGUAGE

Please list age child accomplished the following:

Babble (dada, baba, etc.)	Said first words	Combined words

Does your child respond when his/her name is called? ☐ Yes ☐ No Follow simple directions? ☐ Yes ☐ No

Approximately how many words does your child have? ____

How does your child tell you what he/she wants? ____

Check any areas of concern regarding speech and language:

☐ Length of statements your child uses ☐ Ability to produce sounds correctly
☐ Ability to find the right word (i.e. I want that, uh, that thing, uh, goes around)
☐ Fluency of speech (i.e. I-I-I will go to-to-to school now) ☐ Quality of voice (nasal, horse, pitch)
☐ Ability to stay on topic ☐ Ability to sustain attention ☐ Ability to establish peer relationships
☐ Ability to follow directions

When did you first notice difficulties with your child's speech and language? ____________________________

Does your child become frustrated due to these difficulties? _______________________________________

Family history of speech and language difficulties? ☐ Yes ☐ No Please describe: _____________________

FEEDING

Does your child have any feeding difficulty with the following:
☐ Poor suck ☐ Difficulty swallowing ☐ Difficulty chewing ☐ Gag/choke often

☐ Finger feeding ☐ Spoon use ☐ Required a feeding tube ☐ Reflux/vomiting

☐ List any other feeding concerns ____

Is your child a picky eater? ☐ Yes ☐ No

Does your child dislike particular textures of food? ☐ Yes ☐ No

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HEARING/VISION

Has your child ever had a vision test? ☐ Yes ☐ No If yes, last date performed _____________________
Results ____

Does your child wear glasses? ☐ Yes ☐ No If yes, last date performed ___________________________
Results ____

Does your child wear a hearing aid? ☐ Yes ☐ No If yes, please indicate Left _______ Right ________

SENSORY HISTORY

Do your child's hands, feet, and or tummy seem overly sensitive to touch? ☐ Yes ☐ No

Does your child seem distractible or overactive? ☐ Yes ☐ No
If yes, please describe: ____

Check Yes/No to the corresponding question on the right-hand side:
☐ Yes ☐ No Does your child tolerate tooth brushing?
☐ Yes ☐ No Does your child hesitate on uneven surfaces?
☐ Yes ☐ No Does your child have difficulty position him/her in a chair?
☐ Yes ☐ No Does your child push/bump into other children?
☐ Yes ☐ No Does your child seem generally weak?
☐ Yes ☐ No Does your child have difficulty judging the height/depth of stairs?
☐ Yes ☐ No Does your child walk/go down stairs heavily (stomping feet)?
☐ Yes ☐ No Does your child have difficulty participating in sports with other children?
☐ Yes ☐ No Does your child have a fear of using playground equipment (see-saw, swing)
☐ Yes ☐ No Does your child have difficulty catching him/her when falling?
☐ Yes ☐ No Does your child not hear certain sounds?
☐ Yes ☐ No Does your child respond negatively to certain sounds (running away, crying)?
☐ Yes ☐ No Does your child seem to be a picky eater?
☐ Yes ☐ No Does your child seem to always seek activities with pushing, pulling, jumping?
☐ Yes ☐ No Does your child demand only to wear certain clothes all the time?
☐ Yes ☐ No Does your child avoid getting hands messy?
☐ Yes ☐ No Does your child get bothered by face washing, hair brushing?
☐ Yes ☐ No Does your child spin, rock or hit self when distressed?
☐ Yes ☐ No Does your child have difficulty keeping eyes on task/activity?
☐ Yes ☐ No Does your child close one eye or tip head back when looking at something?

Any concerns you would like to share with us regarding your child? His/her sensory processing. Home or school skills that are not age appropriate.
____
____

What goal would you like your child to work on this year?
____
____

Do you have any questions for us?
____
____

Please list any behavioral issues
____
____

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Are there any behavioral strategies being used?
____
____

Please explain why you want this evaluation done
____
____

Has your child had any previous Evaluations/Therapy? ☐ Yes ☐ No
If yes, please provide dates, facility where performed, type of therapy and reason(s)

Physical: ____

Occupational: ____

EDUCATIONAL HISTORY

What school does your child attend? ________________________________ Current grade level ________________

How often does he/she attend school? ____________________ days per week ___________hours per day _______

What are your child's strengths in school? ____
____
____

What areas at school are the most difficult for your child? ____
____
____

Thank you for taking the time to complete this form. The information you have provided is very valuable in assessing your child's development skills.

Matthew Smith, M.S., CCC-SLP, Executive Director
LA Speech Pathology Services, Inc.
SP#12297