LA SPEECH PATHOLOGY SERVICES, INC.
5625 Windsor Way, Suite #106, Culver City, CA 90230
310.384.5317 | Fax: 310.943.3333 | laspeechguy@gmail.com
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 **Tax ID#**

If yes, specify:

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 _____

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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