Mary Washington
PEDIATRIC THERAPY
a department of Mary Washington Hospital

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OT Progress Update Parent Questionnaire

Today's Date:_____

Patient Name:_____ Date of Birth: _____/ _____ / _____

Person completing form: _____ Relationship to patient: _____

Who is accompanying the child to the evaluation? _____

Have there been any changes to you insurance information? ❑ yes ❑ no
(If yes, please notify the receptionist of the changes)

_____

_____

_____

Current Physician: _____ **Phone:** _____

List any other health care providers or specialist and their phone number.

_____

_____

_____

Any diagnoses (Please list diagnosis and date received)

_____

_____

_____

Please list any medications taken and how often.

_____

_____

_____

Any changes in medical history since the last evaluation? ❑ yes ❑ no
If yes, please explain.

_____

_____

_____

Is your child currently receiving OT services at Mary Washington Pediatric Therapy? ❑ yes ❑ no

Please check the reason(s) for evaluation

- ❑ Fine Motor
- ❑ Sensory
- ❑ Mobility
- ❑ Gross Motor
- ❑ Self Care Skills
- ❑ Handwriting
- ❑ Overactive
- ❑ Under-active
- ❑ Difficulty with transitions
- ❑ Difficulty following directions
- ❑ Difficulty with self regulation skills
- ❑ Difficulty with executive functioning skills
- ❑ Difficulties with attending to tasks
- ❑ Difficulties with sitting at table for tasks for a reasonable length of time
- ❑ Sensory feeding difficulties
- ❑ Have aversions to touch, sight, sounds, or smells
- ❑ Other

Other Value: _____

Does your child receive any other types of services (ST, PT, ABA) and how often?

_____

_____

_____

What goals would you like to see achieved by your child during OT therapy?

_____

_____

_____

Please list any other concerns:

_____

_____

_____