Physical Therapy etc.
142 Franklin Farm Lane
Chambersburg, PA 17202

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Thank you for choosing Physical Therapy etc. We look forward to getting to know your child and working with you to develop a treatment plan to address your child's needs.

Enclosed you will find a pre-evaluation questionnaire. This information will assist us in providing your child with an evaluation tailored to their individual needs and your concerns.

Completed forms may be mailed to or dropped off at our office:

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142 Franklin Farm Lane
Chambersburg, PA 17202

Once the forms have been returned, our office staff will contact you to schedule the initial evaluation appointment and, if applicable, obtain information regarding your insurance coverage.

We participate with many insurance plans. Prior to your child's first visit we will contact your insurer to clarify the available benefits and notify you of our findings prior to the start of the evaluation. We also accept self-payment for services. If you have any questions about self-payment options or your benefits as reported to us by your insurer, our billing office will be happy to speak with you. Unfortunately, we are unable to accept medical ACCESS as payment for services.

Pennsylvania state law requires that OT services be provided under the order of a physician. If your child's physician is unsure what to write on the prescription, "OT evaluation and treatment", is sufficient wording to initiate services.

If you have any questions please feel free to call our office at (717)263-5147, Monday through Thursday from 7:30 a.m. until 6:00 p.m. and Fridays from 7:30 a.m. until 4:00 p.m.

Physical Therapy etc., Pediatric OT Pre-evaluation Questionnaire

To help us better understand your child please complete the following as completely as possible.

Demographic Information:

Child's name:	Child's date of birth:
Child's age:	Date of form completion:
Person(s) completing this form:	Relationship to child:

Referring Information:

Who referred this child for evaluation?

Reason for referral?

What are your primary concerns or goals regarding your child?

When did you first start to have these concerns?

What do you see as your child's strengths?

In one sentence, how would you describe your child?

Do you have any additional information that will help us to better understand your child?

For therapist's use

Intervention History:

Please list any person your child has seen for evaluation and/or services your child has or is receiving currently. (physical therapy, counseling services, mobile therapist, etc.)

Has your child had any of the following evaluations or screenings?- please explain	
Hearing	
Vision	
Psychological	
Neurological	

For therapist's use

Medical History:

Were there any difficulties during pregnancy? Please specify:

Were there any complications during labor and/or delivery? Please specify:

Length of pregnancy:	Length of labor:

Please specify the conditions of your child's birth:			
Premature:	Full-term:	Post-mature:	
Vaginal:	Forceps:	Vacuum:	C-section:

Child's birth weight:

Did your child require assistance to start breathing at birth?

Did your child experience any complications/problems in early infancy? Please specify:

Did your child have any feeding difficulties in early infancy? Please specify:

Does your child have a medical diagnosis? Please explain:

Does your child have now or in the past any significant medical difficulties? Please explain:		
Surgery -		
Hospitalization -		
Respiratory, lung or bronchial difficulties s-		
Cardiac problems -		
History of seizures -		
Allergies -		
Ear infections -	How many -	What ages -
Ear tubes in place -		
Other - please explain:		

Does your child currently take any medications?

Does your child wear glasses?

Does your child use specialized equipment? (wheelchair, feeding tube, ventilator, etc.)

For therapist's use

Developmental History:

Please list the approximate age your child accomplished each activity. Indicate, "not yet", if they have not yet accomplished the skill.

Motor	
Head control-	Reaching for objects-
Roll over both ways-	Sitting alone-
Creeping on all fours-	Pulling to stand-
Walking-	Jumping-
Hopping on one foot-	Riding a bike-
Finger feeding-	Eating with a spoon-
Drawing a circle-	Cutting with scissors-
Using a knife for cutting-	
Does your child have difficulty learning new motor skills? Please explain:	

For therapist's use

Please describe your child as an infant	yes	no	sometimes
Cried a lot, fussy			
Non-demanding			
Alert			
Quiet			
Passive			
Active			
Liked being held			
Resisted being held			
Floppy when held			
Tense when held			
Good sleep patterns			
Irregular sleep patterns			
Any other insights regarding your child's behavior as an infant:			

Please describe your child now	yes	no	sometimes
Mostly quiet			
Overly active			
Tires easily			
Talks compulsively			
Too impulsive			
Restless			
Stubborn			
Resistant to change			
Fights frequently			
Usually happy			
Exhibits frequent temper tantrums			
Clumsy			
Difficulty separating from primary caregiver			
Nervous habits or tics			
Falls often			
Wets bed			
Wets or soils pants (how often)			
Has a poor attention span			
Is frustrated easily			
Has unusual fears			
Rocks self frequently			
Any other insights regarding your child's behavior now:			

For therapist's use

Please describe a typical day for your child from waking till bedtime including whether it is difficult for your child to get to sleep at night and stay asleep.

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For therapist's use

Please answer the following questions. If you indicate "yes" please note if this is a current or past problem.

Occupational History:

Social/Family Living	Does your child-	
Have difficulty socializing with extended family and close friends?	No	Yes- please explain:
Are you limited in attending family/social gatherings because of your child's behavior/reactivity to events?	No	Yes- please explain:
Have difficulty attending birthday parties?	No	Yes- please explain:

Are you unable to leave your child alone with familiar, but not routine caregivers for childcare?	No	Yes- please explain:					
Is your family unable to maintain relationships with other families?	No	Yes- please explain:					
Is your family unable to pursue hobbies and interests?	No	Yes- please explain:					
Is your child able to tolerate social touch or hugs from others?	Yes	No- please explain:					
Does your child have difficulty with different people's voices?	No	Yes:					
		Loud voices	Men's voices	Women's voices	Children's voices	Screaming	Crying
Are routines helpful in getting your child to participate in social situations?	No	Yes- please explain the routine (s):					
What happens if the above routine is disrupted?	No impact	Yes- please explain:					
		Impact on child-					
		Impact on family-					
Any additional comments related to family/social living:							

For therapist's use

Play Skills/Peer interaction	Does your child-				
How long is your child able to play alone?	1-2 minutes	2-5 minutes	5-10 minutes	10-30 minutes	30+ minutes
What are your child's preferred play activities?	Please explain :				
	Child prefers: Sedentary play (video games, reading, puzzles, coloring) or Active play (playing ball, running, swimming, hide and seek)				

Is your child destructive towards toys?	No	Yes- please explain:				
Does your child struggle playing with other children?	No	Yes (circle all the apply)-				
		Parallel play- (playing alongside other children)	Interactive Play- (playing with other children)	Structured group play	Making friends	Pretend play
Is your child preoccupied with seeking intense movement during play?	No	Yes (circle all that apply)-				
		Spinning	Bouncing	Crashing	Jumping	Rocking	Other(s):
Which playground equipment does your child avoid? (circle all that apply)	Swings	Monkey bars	Crawl tunnels	Vertical climbers	Merry-go-round	Ladders
	Slide	Climbing wall	Bridges	Teeter totter	Spring riders	Other(s):
Which playground equipment will your child play on? (circle all that apply)	Swings	Monkey bars	Crawl tunnels	Vertical climbers	Merry-go-round	Ladders
	Slide	Climbing wall	Bridges	Teeter totter	Spring riders	Other(s):
Does your child avoid certain kinds of toys? (musical toys, textured toys)	No	Yes- please explain:				
Does your child exhibit poor safety awareness or engage in activities that are potentially dangerous? (jumping off of high surfaces without worry)	No	Yes- please explain:				
Which of the following messy activities does your child avoid? (circle all that apply)	Sand	Playing in the grass	Finger paint	Play-doh	Glue	Other(s):
Which surfaces does your child have difficulty with? (circle all that apply)	Ascending stairs	Descending stairs	Grass	Gravel driveway	Woodchips	Sand
	Other(s):					
Does your child have poor depth perception? (ducks or blinks when a ball is thrown at him/her, difficulty with stairs)	No	Yes- please explain:				
Which gross motor skills does your child have difficulty with in comparison to same age peers?	hopping	jumping	skipping	running	Riding a tricycle/bicycle	Other(s):

Comments:

For therapist's use

In the community	Is your child-	
Comfortable running errands?	Yes	No- please explain:
Going shopping for groceries, supplies or clothes?	Yes	No- please explain:
Eating in restaurants?	Yes	No- please explain:
Comments:		

For therapist's use

Sleeping	
What time does your child typically awaken?	
What mood is your child typically in upon waking in the morning?	
What time is your child put to bed?	
What time does your child typically fall asleep?	
Where does your child sleep?	

Does your child have difficulty with sleeping?	No	Yes			
		Falling asleep	Staying asleep	Frequent night waking	
		Do family members have interrupted sleep as a result?	Yes	No	
		How would you rate the severity of sleeping issues?			
How many times per night does your child wake?	Almost never	1-2	3-4	5-6	7+

What does your child do when they awaken?	Whimper	Scream	Play with toys	Goes to parents ' room	Puts self back to sleep	Other(s)	
Please describe routines that are helpful for getting your child back to sleep.							
How old was your child when they consistently slept through the night?							
Does your child seem to require too much or too little sleep or at odd times?	No	Yes					
		How many hours nightly?					
		What times of day?					
Does your child take naps?	No	Yes					
		Frequency of naps?					
		Duration of naps?					
		Location of naps?					
		Does your child need help to fall asleep for naps?					
What activities do you use as part of your child's bedtime routine? (circle all that apply)	Bath time	Singing/humming	Reading	Holding	Bouncing	Massage	Rocking	Other(s)
Please describe any necessary specifics regarding your child's bedtime routine.							
What happens if this routine is disrupted?	Impact on the child:						
	Impact on family members:						

For therapist's use

Feeding								
Was your child breastfed as an infant?	No	Yes						
		For how long?						
If your child was bottle fed as an infant, were there any difficulties or concerns?	No	Yes- please explain:						
Did your child have a strong suck as an infant?	No	Yes- please explain:						
Did your child frequently spit up as an infant or have reflux?	No	Yes- please explain:						
Did your child have difficulty with weight gain or appetite as an infant?	No	Yes- please explain:						
Did your child have respiratory problems as an infant?	No	Yes- please explain:						
Does your child refuse to eat, spit out, or gag on foods based on the following characteristics? (circle all that apply)	No	Yes						
		Variety of food selection	Temperature	Food texture	Crunchy foods	Chewy foods	Food color	Mixed food textures
		Comments:						
Does your child have difficulty with ingesting foods? (circle that apply)	No	Yes						
		Chewing a variety of foods	Sucking through a straw	Swallowing a variety of foods	Food falling out of mouth	Frequent choking	Managing mixed food textures	
		Comments:						
Is there a disruption in family mealtime as a result of atypical eating patterns?	No	Yes- please explain:						

Does your child exhibit oral motor sensitivities or seeking? (circle all that apply)	No	Yes			
		Examines objects by placing in mouth	Gags/vomits frequently	Bites/chews objects/clothing frequently	Grinds teeth
Does your child attempt to eat unusual, noxious or inedible substances or place in mouth?	No	Yes- please explain:			
Where does your child eat meals?	Comments:				
What routines do you follow that are helpful for getting your child to eat meals?	Comments:				
What happens if the routines are disrupted?	Impact on your child:				
	Impact on your family:				

For therapist's use

Grooming								
Does your child dislike or resist the tactile feeling of grooming activities? (circle all that apply)	No	Tooth brushing	Bathing	Hair brushing/combing	Face washing	Haircuts	Nail trimming	Blowing nose
		Comments:						

Is your child independent for completion of grooming activities? (circle all that apply)	Yes					
	Tooth brushing	Bathing	Hair brushing/combing	Face washing	Nail trimming	Blowing nose
	Comments:					
Does your child avoid or fear grooming tools? (circle all that apply)	No	Hair dryers	Electric toothbrushes	Barber's clippers	Dentistry tools	Other(s):
		Comments:				
Does your child avoid or fear the sounds associated with grooming activities? (circle all that apply)	No	Hair dryers	Bath water running	Hand Dryer	Toilet flushing	Other(s):
		Comments:				

For therapist's use

Dressing						
Which clothing is your child able to take off independently?	Shirt	Pants	Underwear	Shoes	Socks	Coat
Which clothing is your child able to put on independently?	Shirt	Pants	Underwear	Shoes	Socks	Coat
Which fasteners can your child manage independently?	Snaps	Zippers	Buttons	Tie Shoes		
				Was it a struggle learning to tie?		
				No	Yes	

Is your child selective in the types of clothing textures he/she will wear?	No	Yes
		What types of clothing textures are preferred?
		What clothing textures are avoided?
Does your child express a need for minimal clothing, regardless of weather?	No	Yes- please explain:
Does your child express a need for clothing to cover the entire body or dress in layers, regardless of weather?	No	Yes- please explain:
Does your child frequently adjust clothing, as if uncomfortable?	No	Yes- please explain:
Do tags in clothing or seams in socks bother your child?	No	Yes
		What type of reaction/behavior is seen?

For therapist's use

Toilet Training					
Does your child experience urinary/bowel issues?	Incontinence during the day	Bedwetting	Loose stools	Lack of awareness	Constipation
	How often?	How often?	How often?	How often?	How often?
Is your child toilet trained?	Yes Bladder: (age) Bowel: (age)	No			

Bathing
Does your child prefer a shower or a bath? Please circle.
Does your child become upset/irritable when splashed?
Is your child able to wash themselves independently, with some assistance for thoroughness if needed?

For therapist's use

School Skills							
Where does your child attend preschool or school?	Home school	Daycare	Special needs pre-school class	Regular education class	Special education class	Mix of regular and special education classes	Other:
Does your child exhibit a hand preference?	No	Yes					
		Right			Left		
		Established at what age?					
Does your child frequently change his/her grasp on pencils/other tools?	No	Yes- please explain:					
Which writing skills does your child struggle with/avoid (circle all that apply)	Drawing and/or coloring	Tracing	Copying	Handwriting	Use of graded pressure	Stabilization of paper while drawing and/or writing	Proper desk posture
					Too much / Too little		
Which fine motor skills does your child struggle with/avoid? (circle all that apply)	Grasping and maneuvering scissors				Performing 2 different tasks at the same time (ex- hold and turn paper while cutting, cut food using knife and fork)		
Which skills does your child struggle with? (circle all that apply)	Finding items within a "hidden picture"	Phonetic learning (sounding out of letters to read words)	Telling time	Sequencing months of the year	Puzzles and construction and /or manipulation of materials	Spelling	Responding promptly to verbal instruction	Writing numbers & letters correctly (without frequent reversals)

Can your child draw an easily recognizable picture?	Yes	No- please explain:			
Does your child write up/down hill on paper?	No	Yes- please explain:			
Does your child have difficulty with any of the following? (circle all that apply)	Needing to hold head close to book when reading, paper when writing	Closing/covering one eye while doing near work	Rubs eyes because of a headache when reading or writing	A short attention span when reading or copying information	
	Turning head when reading across a page	Losing place often during reading	Needing finger or marker to keep place while reading	Reading comprehension	
	Reverses letters or words	Rereads or skips words	Doesn't look when manipulating objects		
Does your child have difficulty sitting still?	No	Yes- please explain:			
Does your child fidget while listening?	No	Yes- please explain:			

For therapist's use

Movement Skills		
Does your child become overly excited after movement activities and/or have difficulty calming self after the activity?	No	Yes- please explain:

Does your child like to be wrapped tightly in a sheet or blanket, or seek tight spaces?	No	Yes- please explain:	
Does your child enjoy or want to be hugged more than what would be considered typical?	No	Yes- please explain:	
Does your child assume an upside down position frequently?	No	Yes- please explain:	
Does your child display any of the following movement difficulties? (circle all that apply)	Avoids activities where feet leave the ground	Avoids/fears activities requiring balance	Avoids age appropriate gross motor activities
	Excessive dizziness from swinging, spinning or riding in a car	Stamps/slaps feet on the ground when walking	Loses balance/trips easily or frequently
	Resists having head tilted backwards	Drags feet or has poor heel-toe pattern when walking	Unable to reciprocate feet on stairs
	Fears falling when no real danger exists	Drags hand or bangs object along wall when walking	Difficulty moving from one floor surface to another
	Fearful of being tossed in the air or turned upside down	Lethargic or inactive	Confuses left and right
	Holds head upright when leaning or trying to bend over	Leans on objects/people for stability	Has a poor sense of direction, gets lost easily
	Turns whole body to look at someone	Moves with quick bursts of activities rather than a sustained effort	Dislikes being moved
	Seems weaker or tires more easily than peers	Poor coordination or sense of rhythm	Other:

For therapist's use

Daily Environment Interaction							
Does your child demonstrate an irrational fear of any of the following noises? (circle all that apply)	Vacuum cleaner	Hair Dryer	Fans	Blender	Coffee grinder	Toilet flushing	Dehumidifier
	Air vents	Sirens	Fire alarms	Thunder	Trucks	Other:	Other:
	Comments:						
Is your child confused about the direction of sounds:	No	Yes- please explain:					
Does your child hear sounds before others notice?	No	Yes- please explain:					
Does your child cover their ears to shut out objectionable auditory input or overreact to unexpected noises?	No	Yes- please explain:					
Does your child demonstrate exaggerated or excessive emotional responses to pain?	No	Yes- please explain:					
Does your child demonstrate little or no pain response?	No	Yes- please explain:					
Does your child dislike having their eyes covered or being in the dark?	No	Yes- please explain:					

Is your child overly sensitive to lights or sunlight?	No	Yes- please explain:
Does your child avoid environments and/or objects with certain odors?	No	Yes- please explain:
Does your child seek environments and/or objects with certain odors?	No	Yes- please explain:
Is your child uncomfortable on elevators, escalators or in cars?	No	Yes- please explain:
Does your child avoid busy, unpredictable environments?	No	Yes- please explain:
Does your child have an excessive reaction to light touch sensation?	No	Yes- please explain:
Is your child unresponsive to being touched or bumped?	No	Yes- please explain:
Does your child have an excessive reaction if bumped unexpectedly?	No	Yes- please explain:
Does your child exhibit a lack of safety awareness?	No	Yes- please explain:

Is your child unable to attend sleepovers?	No	Yes- please explain:
Does your child have difficulty with long car rides?	No	Yes- please explain:
Does your child have difficulty with loud, crowded sporting events?	No	Yes- please explain:

For therapist's use

Social Interaction							
Does your child exhibit aggressive behavior?	No	Yes					
		Is it directed towards him/herself?		No		Yes	
		Is it directed towards others?		No		Yes	
		What types of behaviors are exhibited? (circle all that apply)	Biting	Pinching	Kicking	Hitting	Others:
Does your child exhibit tantrums?	No	Yes					
		How frequently do they occur?	times/day?		times/week?		
		What triggers the tantrums?					
		On average, how long do the tantrums last?					
		Describe strategies that are effective for helping calm your child during a tantrum?					
		Are tantrums a source of distress to other family members?		No		Yes	
Is your child easily frustrated, anxious or overwhelmed?	No	Yes- please explain:					

Is your child overly dependent on parent(s) or clingy?	No	Yes				
		Are separations challenging?		No	Yes	
Does your child easily escalate from a whimper to an intense cry?	No	Yes- please explain:				
If your child uses atypical repetitive behavior, which behaviors are demonstrated? (circle all that apply)	Hand flapping	Rocking	Head banging	Jumping	Smelling	
	Breath holding	Humming	Self-talk	Biting	Mouthing objects	
	Visual fixing	Spinning	Teeth grinding	Other:	Other:	
Does your child struggle when there is excessive background sounds/noise in his/her environment?	No	Yes				
		How does your child react?				
Does your child struggle to communicate their own needs, wants or desires?	No	Yes- please explain:				
What is your child's primary form of communication?	Talking	Singing	Sounds and/or vocalizations	Pointing and/or gesturing	Crying and/or screaming	Assistive technology	Other:
How often does your child make eye contact during conversation?	Less than 25% of the time	25% of the time	50% of the time	75% of the time	100% of the time	
Does your child respond to their name being called?	No	Yes- please explain:				
Does your child appear to have an awareness of others?	No	Yes- please explain:				

Does your child appear to have an awareness of self?	Yes	No- please explain:			
How does your child react in new and/or unfamiliar situations?	Please comment:				
Does your child regularly avoid initiation of social interaction?	No	Yes			
		With whom?			
		How often?			
Does your child experience difficulty with language expression? (circle all that apply)	No	Yes			
		Easily frustrated, anxious or overwhelmed	Frequently mispronounces words	Poor articulation, difficult to understand	Difficulty making choices
		Flat, monotonous voice	Hesitant speech	Tendency to stutter	Difficulty expressing emotions verbally
What routines do you follow that are helpful in getting your child to socialize?	Please comment:				

For therapist's use