Emerge - A Child's Place

Pediatric Occupational and Speech Therapy Services
Bonnie J. Hacker, MHS, OTR/L, Director

PARENT QUESTIONNAIRE

Date: _____

Child's Name: _____ DOB: _____ Sex_____

Address:_____

Street City State Zip Code

Home Telephone ( )_____

Who referred child to Emerge: _____

_____

Phone Number _____ Address_____

Reason for Referral: _____

_____

FAMILY INFORMATION:

Parent's Name _____ Birthdate _____

Occupation _____ Cell Phone _____

Place of Employment _____ Business Phone_____

E-Mail Address: _____

Parent's Name _____ Birthdate _____

Occupation _____ Cell Phone _____

Place of Employment _____ Business Phone_____

E-mail Address:_____

With whom does child live?

Biological Parent(s)_____ Adoptive Parents_____ (Adopted at Age_____)

Other (Specify) _____

Health Insurance company _____

List all other persons living in home:

Name Age Relationship to child

_____

_____

_____

_____

BIRTH INFORMATION:

Any difficulties during pregnancy or delivery (Specify)_____

_____

Length of Pregnancy_____ Length of Labor_____ Birth Weight_____

Any problems in newborn period (Specify) _____

_____

_____

SCHOOL HISTORY: where dates

Preschool or daycare_____

Kindergarten_____

Elementary School _____

Present grade_____ School _____

Teacher _____Phone number _____

Is your child in a special class or receiving any support services?

List:_____

DEVELOPMENTAL MILESTONES:

Specify the age at which your child (leave blank if not applicable or you don't remember):

Sat without support _____

Crept on hands & knees_____

Walked independently_____

Jumped _____

Rode a tricycle _____

Dressed independently _____

Named simple objects _____

Rode a bicycle (no training wheels) _____

Used single words (e.g., no, mom, doggie, etc.) _____

Combined words (e.g., me go, daddy shoe, etc.) _____

Used simple questions (e.g. Where's cup?, etc.) _____

Engaged in a conversation _____

Drew a recognizable picture _____

Cut out a shape with scissors_____

Do or did you have any concerns about your child's achievement of early developmental milestones? ___ If yes, please describe:

_____

_____

_____

_____

PROFESSIONAL AND MEDICAL CONTACTS:

Check any of the following with whom you have had contact concerning your child. If any of

these professionals have tested your child, please include a copy of the report.

Name Address Phone #

___ Pediatrician _____

___ Psychologist_____

___ Tutor _____

___ Occupational Therapist _____

___ Physical Therapist _____

___ Speech Therapist _____

___ Neurologist _____

___ other (specify) _____

List any medications that your child is currently taking:

_____

List any allergies your child has (including food):

_____

Has your child had any surgeries? If yes, what type and when (e.g. tonsillectomy, tube placement, etc.)? _____

Has your child's hearing been tested (when and results): _____

_____

Has your child's vision been tested (when and results): _____

_____

ACTIVITY HISTORY :

Activity	Current	Past	Child's Reaction to Experience
Gymnastics			
Music Class/lessons			
Dance or movement class			
Karate or Tae Kwon Do			
Scouting			
Organized sports			
Other			

What does your child enjoy playing with? How does your child entertain him/herself?

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What are your concerns about your child?

What have you been told by doctors, teachers and/or others about your child?
Please include any diagnoses you have been given.

What do you see as your child's strengths?

Please list a typical day on the back of this questionnaire, particularly if you have any behavioral concerns.

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