OCCUPATIONAL/SPEECH THERAPY REFERRAL QUESTIONNAIRE

GENERAL INFORMATION

Today's Date: ______________________________

Child's Name: ___________________________________ Date of Birth: _______________________________

Parents/Guardians: ____

Address: ____ City/State/Zip: _____________________________

Home Phone: _____________________________________ Cell Phone:__________________________________

Father's Employer: _________________________________ Phone: ____________________________________

Mother's Employer: ________________________________ Phone: ____________________________________

Names/age of Siblings. Please include any important information about siblings that would be helpful:

____

____

____

Family Structure: Please tell us any important regarding your opinion of your current family relationship and living circumstances. Please include child's relationship with parents, siblings, and other family members. Also, please include marital status of parents and if there are any step-parents or siblings involved.

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____

Child's Physician: (Name, Clinic & Location, phone)

____

____

Available therapy times:

____

____

REFERALL INFORMATION AND CONCERNS

Who referred you and your child to *Kidspeak ltd.*? ____

____

What are the reasons for referral? ____

____

Does your child have a medical diagnosis? ____________ If so, what is the diagnosis? ___________________________

Where was your child's diagnostic evaluation completed? ______________________________________

When was the evaluation completed? ____

What are your major concerns regarding your child? Be as specific as possible. ________________________________

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____

Please list differing opinions of family members involved with the child regarding the child's primary concerns and problem areas. Please also include how specific concerns are currently handled. ________________________________

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SCHOOL INFORMATION

What school does your child attend? ____

School Address: ____

____

School Phone Number: ____

Teacher's Name: ____ Grade:__________________

What specific concerns has your child's teacher noted within the classroom and how are these issues currently addressed? ____

____

____

____

What type of classroom is your child in (Regular Ed, Special Ed, Montessori, etc)? ______________________________

____

Does your child have an IEP? ________ What types of special services does he/she receive? __________________

____

____

Case Manager: ____

Occupational Therapist: ____

Speech/Language Pathologist: ____

(Optional) Other Contact: ____

MEDICAL INFORMATION

Please describe you child's birth history. Include weeks of gestation, vaginal/caesarean section, and any complications during pregnancy, birth, or infancy. If adopted, please indicate and list any known pregnancy or birth history.

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____

Please list any major illnesses, injuries, or surgeries your child has experienced and dates if known:

____

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____

____

List any medications or supplements your child is currently receiving and frequency of dosages:

____

____

____

Are there any medical precautions the therapist should be aware of when working with your child?

____

____

Has your child had a vision test? Yes____ No____. If yes, when? ______________________________

Where? ____

Results/Recommendations: ____

Has your child has a hearing test? Yes ____ No ____. If yes, when? ____________________________

Where? ____

Results/Recommendations: ____

Does your child have any assistive devices? Check all that apply.

_____ Glasses _____ Wheelchair _____ AFO's _____ Orthotics

_____ Hearing Aids _____ Other: ____

Does your child have a history of ear infections? If yes, please describe frequency of occurrence and method of treatment. ____

____

Does your child have any allergies? If yes, please list what your child is allergic to and how these allergies are treated.

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____

PAST SERVICES

Has your child had outpatient speech/language or occupational therapy in the past? If yes, please outline below:

Dates (Start – End)	Location	General Goal Areas	Reason for Discharge

DEVELOPMENTAL HISTORY

Please list approximate ages your child met the following developmental milestones:

Rolled Over		Coo	
Sat Alone		Babble	
Crawled		Imitate Sounds/Words	
Walked		Respond to "no-no"	
		Said 1st word	
Play Pattycake/Peek-a-boo		Put 2-3 word together	
Alternate turns		Spoke in sentences	
Play appropriately with toys		Began asking questions	

Does or did your child demonstrate the following behaviors in infancy or early childhood:

Have feeding difficulties? Yes______ No______. If yes, please describe: ______________________________

____

Have sleeping problems? Yes______ No______. If yes, please describe: ______________________________

____

Have colic? Yes______ No_______. If yes, for how long? ______________________________________

Prefer certain positions as an infant? Yes______ No______. If yes, describe: ___________________________

____

Dislike lying on stomach? Yes_______ No______. Dislike lying on back? Yes______ No______.

Enjoy bouncing? Yes______ No_______. Calmed by car rides or swings? Yes ______ No______.

Become nauseated by car rides or swings? Yes______ No______.

Tend to be compliant? Yes______ No______.   Go through a “terrible twos”? Yes_______ No_______.

COMMUNICATION SKILLS

Does your child have frequent interactions with other children? (i.e. playing with siblings, attending daycare, etc.)? If so, please describe:____
____

Does/did your child make gestures (i.e. waves bye-bye, imitates others clapping, bangs on objects to get your attention, points to reference objects, dance to music, blows a kiss, nods yes/no, makes funny faces to get a laugh…etc.)
____
____

Please provide any additional information here such as emotional regulation, joint attention, social interaction, etc:
____
____
____

Please indicate the frequency your child does each of the tasks below:

FUNCTIONAL COMMUNICATION	Frequently Observed	Occasionally Observed	Not Observed
Attempts to say words			
Understands what is said to him/her…			
• a few words (i.e. body parts or identify pictures in a book)			
• simple directions			
• many words and phrases			
• almost everything I say			
Communicates wants and needs to others by speaking			
Communicates wants and needs to others without speaking (i.e. using gestures, facial expressions, communication device, etc.)			
Communicates successfully with peers			
Speech can be understood by unfamiliar listeners			
SPEECH ACTS AND COMMUNICATION FUNCTIONS	Frequently Observed	Occasionally Observed	Not Observed
Labels things or actions			
Asks for things or actions			
Describes things or actions			
Asks for information			
Gives information			
Makes requests			
Makes promises			
Agrees			
Threatens or warns			
Apologizes			
Protests, argues, or disagrees			
Show humor, teases			
Uses greetings			
DISCOURSE SKILLS	Frequently Observed	Occasionally Observed	Not Observed
Starts a conversation			

Shows listening behavior			
Responds with appropriate content			
Interrupts appropriately			
Stays on topic			
Changes topic appropriately			
Appropriately ends a conversation			
Recognizes listener's viewpoint			
Demonstrates topic relevancy			
Uses appropriate response length			

How does your child let you know what he or she wants? (Check all that apply.)

_____ Cries
_____ Points
_____ Uses gestures
_____ Makes a few sounds
_____ Makes many different sounds
_____ Indicates "yes" or "no"
_____ Uses few words
_____ Says many word, one at a time
_____ Uses two or three word sentences
_____ Uses long sentences
_____ Asks questions

Is your child using spoken words to communicate? __________. If not, have they developed an alternative communication systems (i.e. gestures, signs, PECS, AAC device, etc.)? ____

____

Can people in your family understand your child's speech? ____

____

Can people *outside* of your family understand your child's speech? ____

____

Is your child aware of others difficulty understanding him/her? ____

____

Does your child appear frustrated if he/she is not understood? ________ If so, what do they do to show their frustration?

____

Please provide any additional information here regarding your child's communication:

____

____

____

____

FEEDING

Do you have concerns about your child's eating/feeding skills? ______ No (Skip to Activities of Daily Living section)

______ Yes (Please complete the following questions)

Does your child have more than 10 foods in his/her diet? Yes_____ No _____. If no, what foods does your child prefer? ____

____

____

Does your child have a limited variety of textures in his/her diet (ie. no purees, no crunchy foods, temperature sensitivity, cooked verses raw etc)?

____

____

____

Does your child's diet include fruits and vegetables? Yes_____ No______. If yes, please list items: ______________

____

____

Does your child's diet include a variety of protein? Yes______ No______. If yes, please list items: ______________

____

____

Does your child drink from a *bottle, sippy cup, straw, or open cup*?____

Briefly describe mealtime in your home: ____

____

____

____

____

Additional Comments (regarding feeding): ____

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ACTIVITIES OF DAILY LIVING

Please describe your child's skills and behaviors for each of the following:

Dressing Skills (level of independence/amount of assistance needed; type of clothing your child wears; how long it takes to get dressed; behavior during dressing; etc.): ____

____

____

Hygiene (bathing skills; ability to wash hands; wash face; brush hair; brush teeth; nail cutting; behavior and tolerance of these): ____

____

____

Toileting (potty trained; level of independence with peri-care; etc.): ____

____

Transitions (how your child adapts to change between people or environments; need for preparation regarding change in routine or schedule; need for rituals, routines or control, etc.): ____

____

____

Attention/Visual Attention (ability to sustain visual attention; what typically engages your child's attention; how distractible is your child; length of time your child can attend to a preferred, non-preferred, or new activity; etc.):

____

____

____

Intensity Level/Mood (level of energy for a particular activity; emotional or aggressive behaviors to touch, movement sensations, or play choices; sense of humor; any mood swings; emotions related to specific situations; facial affect; etc):

____

____

____

Sleep Patterns (bedtime routine, difficulty falling asleep, waking up throughout the night, etc.):

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____

Household Responsibilities: What jobs/tasks does your child complete at home? Please list and explain, if needed.

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____

Play Skills (ability to share toys, engage with familiar and novel toys; overall play exploration; turn taking ability; ages of people he/she chooses to play with; number of people your child is comfortable playing with; is your child a leader, follower or a loner; etc): ____

____

____

- What type of toys/play does your child enjoy?

  ____

  ____

- How long can your child engage in a play-based activity independently and with adult support?

  ____

  ____

- How do you engage in play with your child? (Roughhousing, pretend play, electronics, direct play, structured/unstructured, etc).

  ____

  ____

- What do you like to do with your child? What activities does your family like to do together?

  ____

  ____

Exploration (reaction to new environments, unfamiliar people, places, foods, procedures, etc): ____________________

____

____

Motor Skills (how coordinated is your child with gross motor play such as running, kicking, catching, using both sides of his/her body together; how do you perceive your child's fine motor ability, etc): ______________________________

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OTHER INFORMATION

What community activities does your son/daughter participate in? ____

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Is there any other information that you feel is important for us to know? ____

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