



Information Form for OT Consultation

Date

Parents' names

Full address

Phone number

Email

Child's name

Child's birthdate

School and grade level

Other professionals (doctor, psychologist, speech therapist, educational specialist) working with child:

Referred by

Dear Parent/Guardian,

We are pleased that you have contacted our clinic. We would appreciate your answering those questions below which pertain to your child's needs and developmental goals. All information will be kept completely confidential. We look forward to connecting with you personally in the very near future.

Jeff Marks, Director, PlaySteps for Developing Kids

Areas of concern for your child and what you hope to gain from therapy:

Please check the appropriate box for each yes/no question below.

Handwriting Skills

1. Does your child:

• hold the pencil in an unconventional way?	yes	no
• tend to write faster than peers?	yes	no
• tend to write more slowly than peers?	yes	no
• avoid handwriting instruction? (for younger children)	yes	no
• minimize/avoid writing? (for older children)	yes	no
• respond more fully when writing isn't required?	yes	no
• complain of hand fatigue, or shake out hand after a few minutes?	yes	no
2. Is the writing itself hard to read? yes no
3. Does the quality of the writing decline after the first minute or two? yes no

- | | | |
|--|-----|----|
| 4. Has handwriting always been a challenge for your child? | yes | no |
|--|-----|----|

If yes on any of the above questions, please explain:

Fine Motor Skills

- | | | |
|---|-----|----|
| 1. Does your child have difficulties with self-care skills such as: | | |
| • holding eating utensils
(continuing to use an in-palm grasp rather than 1st
three fingers)? | yes | no |
| • opening food containers? | yes | no |
| • manipulating buttons/snaps, connecting zipper sides? | yes | no |
| • tying his/her shoes? | yes | no |
| 2. Is there any difficulty using the two hands together, such as: | | |
| • cutting with scissors? | yes | no |
| • coloring
(holding the paper with the non-dominant hand)? | yes | no |
| • stringing beads? | yes | no |
| • holding an object with one hand and manipulating it
with the other? | yes | no |
| 3. Is there an absence of consistent hand preference?
Or is right/left hand preference inconsistent? | yes | no |
| | yes | no |
- If yes on any of the above questions, please explain:

Gross Motor Skills

- | | | |
|--|-----|----|
| 1. Does your child have difficulties with gross motor skills such as: | | |
| • jumping with two feet? | yes | no |
| • hopping on one foot? | yes | no |
| • running? | yes | no |
| • skipping? | yes | no |
| • climbing? | yes | no |
| • riding a bike? | yes | no |
| • pumping a swing? | yes | no |
| • sitting upright at a desk/table? | yes | no |
| 2. Does your child bump into things or people
or misjudge space often? | yes | no |
| 3. Does maintaining his/her balance seem to be
a challenge for your child? | yes | no |
| 4. Does your child have difficulty learning new movement
sequences (e.g. swimming lessons, martial arts, gymnastics)? | yes | no |
| 5. Does your child avoid movement activities? | yes | no |

If yes on any of the above questions, please explain:

Sensory Modulation

1. Is your child over or under responsive to:
- | | | |
|-----------|-----|----|
| sound? | yes | no |
| touch? | yes | no |
| movement? | yes | no |

If yes on any of the above, please answer the following

questions: Does your child (compared to other children) seem:

- more bothered than others by loud noises or noisy environments?

yes	no
-----	----
- more likely to notice background noises?

yes	no
-----	----
- more likely to not notice sound at all?

yes	no
-----	----
- bothered by tags and seams, or certain clothing textures?

yes	no
-----	----
- upset with grooming tasks (e.g. brushing teeth or hair, haircuts, sunscreen, etc.)?

yes	no
-----	----
- upset and/or “rubs out” the area touched when touched unexpectedly?

yes	no
-----	----
- to react differently to pain?

yes	no
-----	----
- distressed by or will avoid messy stuff?

yes	no
-----	----
- to seek messy play?

yes	no
-----	----
- not to notice if he/she has food on his/her face?

yes	no
-----	----
- to seek strong hugs and/or push into people?

yes	no
-----	----
- to be a picky eater?

yes	no
-----	----
- to avoid/refuse certain food textures?

yes	no
-----	----
- to avoid certain kinds of movement?

yes	no
-----	----
- to seek certain kinds of movement?

yes	no
-----	----
- to exhibit increased or decreased attention, impulsivity and activity level in different situations or environments?

yes	no
-----	----
- to have trouble remaining in busy or group situations (e.g. restaurants, indoor gyms, standing in line)?

yes	no
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If yes on any of the above questions, please explain:

What are the biggest factors that impede your child's performance?

Functional Vision and Perception

1. Does your child have difficulty with visual tasks such as:
 - lining up math problems?
 - spacing and sizing letters and words?
 - copying from the white board?
 - skipping words or losing place when reading?
 - reversals of words or letters beyond 1st grade?
 - eye fatigue or headaches?

Infant & Toddler Behaviors (Please only fill out this section if your child is an infant or toddler.)

1. What are your child's night time and nap time sleep patterns?
2. Does your child have any feeding or diet challenges?
3. Describe your child's emotional regulation. Does he/she experience fussiness, tantrums, inflexibility, or inability to self-soothe?
4. Describe your child's social engagement with adults and other children.

(continue to final page)

