



## Sari Ockner, OTR/L

Pediatric Occupational Therapy

Sensory Integration, Handwriting, and Child Development Specialist

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Date of Birth: \_\_\_\_\_

Child's Age: \_\_\_\_\_

Parents Names & Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone numbers: (H) \_\_\_\_\_ (C) \_\_\_\_\_

(W) \_\_\_\_\_ Other: \_\_\_\_\_

Parent email: \_\_\_\_\_

Child's School: \_\_\_\_\_

Grade: \_\_\_\_\_

Name's of Sibling(s) \_\_\_\_\_

**Concerns & reasons for referral to Occupational Therapy:**

## I. BACKGROUND/MEDICAL HISTORY

(please circle Yes/No and make any necessary comments):

Is your child generally in good health?	Y	N
Does your child wear glasses?	Y	N
Has your child's vision been checked?	Y	N
Has your child's hearing been tested?	Y	N
Does your child have any allergies?	Y	N
Does your child have a medical diagnosis?	Y	N

Please comment on anything pertinent to your child's current health status:

### BIRTH HISTORY:

My child was born at \_\_\_\_\_ weeks of gestation

My child spent \_\_\_\_\_ days/months in the hospital following birth

Please describe any complications pre/post deliver:

### MOTOR MILESTONES:

Rolled at \_\_\_\_\_ months

Sat independently at \_\_\_\_\_ months

Crawled at \_\_\_\_\_ months\*

Walked at \_\_\_\_\_ months

\*Did your child crawl on all four extremities or "combat crawl"?

## II. CURRENT SKILL LEVELS

Please use the following key when completing the checklist that follows:

[1] = A consistent problem (as compared to same age peers)

[2] = Sometimes a problem

[3] = Not an area of concern (adequate skills or not applicable)

SELF HELP SKILLS: Your child's ability to manage personal needs within home, school, or community

1 2 3 Has difficulty taking off or putting on coat, boots, etc.

1 2 3 Has difficulty manipulating fasteners (buttons, snaps, zippers, Velcro on shoes)

- 1 2 3 Has difficulty tying shoe laces (age 6+)
- 1 2 3 Has difficulty using eating utensils
- 1 2 3 Has difficulty transitioning between activities

Comments:

POSTURE & FUNCTIONAL MOBILITY: Your child's ability to perform basic developmental motor skills, posture, and balance needed to function in and move throughout their environment.

- 1 2 3 Moves/fidgets excessively while at desk/table, unable to sit still
- 1 2 3 Has difficulty maintaining posture at desk (slumps, head in hand, etc.)
- 1 2 3 Complains of or frequently appears fatigued
- 1 2 3 Has difficulty maintaining sitting position on floor
- 1 2 3 Has difficulty carrying school supplies/belongings
- 1 2 3 Trips or stumbles frequently
- 1 2 3 Has difficulty negotiating playground equipment
- 1 2 3 Weak muscles

Comments:

FINE MOTOR/PERCEPTUAL SKILLS: Your child's ability to manipulate and manage materials at home and/or within their educational environment.

#### **A. Fine Manipulation Skills**

- 1 2 3 Has difficulty holding a pencil
- 1 2 3 Has difficulty cutting with scissors
- 1 2 3 Takes excessive amount of time/practice to learn new fine motor skills
- 1 2 3 Avoids/dislikes/appears to struggle with fine motor activities (puzzles, small

pieces in games, craft activities, drops small items a lot)

1 2 3 Switches hands while writing, cutting, etc. (if still apparent in Kindergarten)

**B. Handwriting** (motor aspect; not content, spelling, grammar, etc.)

1 2 3 Writing is frequently illegible

1 2 3 Forms letters poorly

1 2 3 Has difficulty writing on line

1 2 3 Letter/number size is inconsistent

1 2 3 Writing appears to require excessive effort/requires excessive time to write

1 2 3 Tends to press too hard on the pencil

1 2 3 Applies too little pressure on the pencil

1 2 3 Has difficulty spacing properly between words

**C. Visual Perceptual/Visual Motor**

1 2 3 Has difficulty with puzzles, shape sorters

1 2 3 Has difficulty accurately copying text from books/papers/classroom board

1 2 3 Has difficulty aligning vertical columns; math problems, spelling lists

1 2 3 Frequently reverses letters/numbers

1 2 3 Is unable to recognize/identify shapes/letters/numbers

Comments:

SENSORY PROCESSING: Your child's ability to process relevant sensory information and screen out irrelevant sensory information for effective participation within the educational environment.

**A. Tactile Processing**

1 2 3 Has difficulty tolerating touch or other children in close proximity

(i.e. in line, at circle time, during group work, or on play dates).

1 2 3 Appears to dislike getting hands messy (i.e. art, glue, water, etc.)

1 2 3 Intense reactions to clothing labels, face washing, tooth brushing

## **B. Movement/Vestibular Processing**

1 2 3 Appears avoids/hesitant/afraid of movement activities

1 2 3 Appears to be in constant motion; unable to sit still for an activity

1 2 3 Seeks quantities of movement (e.g. swinging, spinning, bouncing, and jumping)

1 2 3 Gets car sick

## **C. Body Awareness/Proprioceptive Processing**

1 2 3 Has difficulty negotiating body as he/she moves through the environment (i.e. bumping into others or objects, gets lost in familiar places)

1 2 3 Has difficulty respecting the personal space/boundaries of others, (i.e. positions self too close to others, leans on others)

1 2 3 Appears to lack safety awareness/judgment

1 2 3 Seeks quantities of jumping/crashing, hanging on people or furniture, deep pressure, runs or bumps into walls/doors/people

## **D. Auditory Processing**

1 2 3 Appears overly sensitive to loud noises (e.g. bells, toilet flush, sirens)

1 2 3 Becomes distressed during large gatherings, birthday parties

1 2 3 Covers ears to protect them from sound

1 2 3 Distracted or has trouble functioning if there is a lot of background noise

## **E. Oral Processing**

1 2 3 Places non-food objects in mouth (i.e. shirt collar/sleeve, toys)

1 2 3 Picky eater in regards to food texture, tastes, smells, temperature

1 2 3 Gags easily when tooth brushing, trying new foods

**Please discuss your child's strengths:**

**Please list desired therapy goals and outcomes:**

Thank you for taking the time to fill out this questionnaire. All the information provided will be helpful in the evaluation process. Please bring with you to the initial evaluation.

- Sari Ockner, OTR/L