Patient Name

DOB:

MR #

UW Health **uwhealth.org**
(University of Wisconsin Hospitals and Clinics Authority)

OCCUPATIONAL THERAPY SENSORIMOTOR QUESTIONNAIRE

Evaluation Date: _____

Social History: Who is in the child's household(s)?

****What are your primary areas of concern for occupational therapy?****

Development and Medical History:

1. Were there any complications during pregnancy, labor, and/or delivery?

2. What was your child like as an infant? Were they a content baby? When did they sleep through the night? Did they eat well? Did they have trouble sucking or accepting new foods? Did they like to be help?

3. Were developmental milestones met on time? If not please describe.

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4. Does your child have any history of frequent illness including ear infections? What treatments have been used? Do they have PE tubes?

5. Does your child have any allergies? If so, what are they?

6. What medications is your child currently taking?

7. Has your child received any terapy services in the past (Birth-3, Early Childhood, private therapy)? **Are they currently receiving any therapy?**

8. Where does your child currently attend school?

School	
Grade	
Teacher	
Schedule (i.e. half days, full days, etc):	
Does child have an IEP?	☐ Yes ☐ No
Special Services Frequency	☐ Occupational Therapy ☐ Physical Therapy ☐ Speech Therapy ☐ Other _____ _____ _____ _____
Name of Therapists	

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Activities if Daily Living/Self-Care:

1. Please describe your child's typical morning routine.

2. Please describe how your child typically gets dressed. Including if they have certain preferences for specific fabrics, how much help they need, and if they are able to manipulate fasteners.

3. Describe how your face completes or participates in the following self-care tasks:
   Hand/Face washing:

   Bathing:

   Grooming (hair brushing, haircuts, nail cutting,):

   Oral care (tooth brushing, dental care):

4. Is your child toilet trained? ☐ Yes ☐ No If so, what age was this achieved? _____

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5. Please describe a typical mealtime with your child. Are they a picky eater and if so what foods do they prefer? Do they seem aware of internal hunger cues and what is their appetite like? Are they able to feed themselves and use utensils (fork, spoon, open cup) independently?

6. What is your child's typical bedtime routine? Do they fall asleep easily? Do they sleep through the night? Do they seem well rested in the morning?

Sensory Components

1. Does your child seem sensitive to any particular sounds? How do they respond to unexpected or loud noises?

2. Does your child wear glasses or have a diagnosed vision problem? Are they distracted by visual stimuli? Are they sensitive to light?

3. Are there certain textures that they avoid? If so, what are they? Are there certain textures that they enjoy?

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4. Is there a specific time of day or under particular circumstances that your child seems more irritable?

5. Does your child use any strategies to help them calm? If so, what are they?

6. Does your child respond to movement? What movement activities do they like to do? Do they seem more active than other children? Are there specific movement activities that they avoid? Do they ever get carsick or nauseated by movement?

7. Are they able to ride a bike? ☐ Yes ☐ No ☐ Not Applicable

8. How would you describe their balance skills?

9. How do they ascend/descend the stairs?

<u>Social/Behavioral Components</u>

1. How does your child react to new situations or environments?

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2. Do they make friends easily? Do they tend to play best with children their same age? Is it easy to play with them and keep their attention? How long can the stay involved in a play situation with an adult, with a child? Do they seem overly sensitive or are their feelings easily hurt?

3. Describe your child's organizational skills. Are they able to keep track of their belongings? Do they often loose things?

4. How does your child do during the school day? What areas do they find challenging? What do they do well in?

5. Does your child experience "melt-downs"?
   If so, how often do they occur, and how long do they last? Are they able to recover quickly? What triggers have you noticed? What works to end them?

6. What would you describe as your child's strengths?