Western Michigan University Occupational Therapy
Pediatric Clinic

CHILD-PARENT QUESTIONNAIRE

Servicing families and their children

FAMILY BACKGROUND

Child's Name _____ DOB/Age/M/F _____
Parent(s) _____
Address _____ Cell Phone _____
_____ Email: _____
Is there a language other than English spoken in the home? Yes___ No __
How did you hear about the WMU OT Clinic ? _____

Child lives with: ___ Birth Parents ___ Foster Parents ___ Adoptive Parents
____Other

Other children in the family:

Name	Age	Sex	Grade	Any developmental concerns

Are there any cultural norms that you would like us to know about that might impact delivery of services for your child? __Yes __No Explain_____
_____

Are there any religious or spiritual needs that would be helpful to know that might affect delivery of services for your child? __Yes __No Explain _____
_____

PREGNANCY HISTORY

1. Did mom have regular prenatal care? Yes___ No___
2. Did mom have any health problems during pregnancy Yes___ No___
   Explain

BIRTH HISTORY

1. Where was your child born? _____
2. Delivery was: preterm___ term___ post term___ vaginal___
   cesarean section___
3. Were there any complications during delivery? Yes____ No____
   If yes, explain _____
4. Were there any problems with baby or mom in the hospital after birth? Yes___ No___
   If yes, explain _____
   _____
5. Birth weight: _____ Birth height: _____ Apgar Scores: _____

GENERAL HEALTH HISTORY

Physician _____

Address _____

Street city state zip

Phone _____

Specialists _____

Are immunizations up to date? Yes ____ No_____

Does your child take any medications on a regular basis? Yes___ No _____

If so, please describe _____

Medical diagnosis _____

As far as you know, has your child had difficulty with any of the following:

Allergies__	heart__	eczema__	stomach or bowel__	anemia__
feeding__	asthma__	vision__	frequent fevers__	hearing__
ear infections__	ear tubes__	meningitis__	seizures__	sleeping__
head injury__	other/please explain_____			

Has your child had any accidents or injuries? ____Yes ____No

If yes, please explain _____

DEVELOPMENTAL HISTORY

Please give the approximate age that your child did the following:

Smiled_____	Reached out for objects_____	Sat unsupported_____
Crawled on hands and knees_____		Walked alone_____

Please indicate which words describe your child.

affectionate__	demanding__	playful__	overactive__	calm__
good disposition__	shy__	angry__	stubborn__	hard to comfort__
curious__	sad__	likes people__	confident__	fearful__
joyful__	fearless__	other__		

Do you have any concerns about your child's:

	Yes	No	Not Sure
Height	___	___	_____
Weight	___	___	_____
Head size	___	___	_____
Vision	___	___	_____
Hearing	___	___	_____
Movement	___	___	_____
Behavior	___	___	_____
Speech/Language	___	___	_____
Eating	___	___	_____
Nutrition	___	___	_____
Sleeping	___	___	_____
Sensory Processing	___	___	_____

SCHOOL HISTORY

If your child is in school, please answer the following:

School/Grade: _____
Child's favorite part of school: _____

Is your child having difficulty in school? Yes __ No__
Explain _____
_____.

Is your child receiving any help in school? Yes___ No__
Explain_____
_____

THERAPY HISTORY

Has your child ever had therapy services? Yes___ No_____
If yes, please describe: _____
_____

***Please bring any OT evaluations, IFSP/IEPs, or other documents that would help evaluate plan for your child.**

What do you see as your child's strengths?

_____
_____
_____

What are your primary concerns for your child?

_____
_____
_____

What are some questions that you would like answered?

_____
_____
_____

ADDITIONAL COMMENTS

Please return completed form to: tracy.young@wmich.edu

Form completed by_____ Relationship to Child_____
Date_____