OCCUPATIONAL THERAPY CONNECTIONS LLC
6801 LAKE PLAZA DRIVE, SUITE A101a
INDIANAPOLIS, IN 46220
(317) 581-1185 FAX (317) 581-1355

Evaluation Appointment Information

We look forward to beginning the evaluation process with your child. As part of that process, we ask that you fill out the enclosed questionnaires which will provide information about your child's behavioral responses to everyday sensory experiences, and the ability to use information from the senses to develop skills. The information will also provide necessary background information.

- *Questionnaires:* Please complete the questionnaire before you come to the evaluation appointment and bring them with you to the evaluation. The therapist must have this information the day of the evaluation.
  - You may also email the completed forms to us at therapy@otconnections.com
  - You may also fax the completed forms to us at (317) 581-1355

- *Handwriting:* If your child is writing, please bring a sample of your child's handwriting.

- *Shoes:* We ask that your child wear stable shoes, such as tennis shoes, in order to effectively evaluate balance, etc.

- ***Eyeglasses:*** If your child wears eyeglasses, please bring them with you to the evaluation.

- ***Doctor's Referral****:* If you are requesting the referral from your child's doctor, please ask that the doctor specify, **"occupational therapy evaluation and treatment"** on the referral form. The referral may be faxed to us at 317-581-1355 or you may bring it with you to the evaluation.
  Legally we *must* have a hard copy of the referral at our clinic when we perform the evaluation. Without this we will need to re-schedule the evaluation appointment.

- We ask that your child please not eat or drink much caffeine and/or sugar prior to the evaluation.

- Please plan on approximately 1 1/2 hours for the evaluation unless the therapist informs you differently.

- Please remain at this clinic the entire time that your child is having the evaluation session.

- We ask that you not use your cellular (mobile) phone while in the waiting room unless there is an urgent situation. If you must use your phone, please use a soft voice while speaking in order to not disturb others.

- Due to clients' sensitivities to certain chemicals and fragrances, please ***do not wear scented body care products on the day of your appointment*** (i.e., scented lotions, colognes, fragranced hair care products, etc.).

Please do not hesitate to contact this clinic with any questions that you might have. We look forward to meeting you and your child.

Sincerely,

Carol Neu-Frauman, MS, OTR/L

OTC 1/2016

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Background Information: Children

Date_____

I. General Information

Parent/Guardian Name:_____
(first) (last)

Child's Name:_____
(first) (last)

Birth Date:_____ Gender: Male_____ Female_____

Address:_____ City/State/Zip:_____

Phone Numbers (home, work, cell):_____

Email Address:_____ Brothers/Sisters_____

Emergency Contact Person:_____
(name) (relationship) (phone number)

Physician:_____ Referred by:_____
(name) (phone number)

School or Preschool Attended:_____ Grade in School:_____

II. Medical Information:

Medical Diagnosis (If any):_____

Medications taken:_____

Does your child have any of the following	___Speech / Language disorders_____
___ Attention Deficit (Hyperactivity) Disorder	___ Food allergies/special diet_____
___ Autism	___ Muscular weakness_____
___ Asperger's Syndrome	___ Seizures / Epilepsy_____
___ Pervasive Developmental Disorder	___ Vision problems_____
___ Tourette's Syndrome	___ Hearing problems_____
___ Learning Disabilities	___ History of ear infections_____
___ Bipolar Disorder	___ Tubes in ears_____
___ Anxiety	___ Allergies or asthma_____
___ Depression	___ Allergies (latex, medication):_____
___ Posttraumatic Stress Disorder	___ Stomach or intestinal problems:_____
___ Panic attacks	___ Casts or braces:_____
___ Obsessive Compulsive Disorder	___ Surgery:_____
___ Attachment Disorders	___ Serious injury:_____
___ Other mental health disorder	___ Other:_____

Describe any hospitalizations.:_____

Has child had vision test? Yes/No Results? _____ Has child had hearing test? Yes/No Results?_____

Child's height _____ Child's weight _____

Has child been seen by occupational therapy in the past? If so, when, where and for what reason:_____

_____

Please list and *include reports* from other evaluations or treatments your child has received (psychologist, PT, neurologist, OT, etc.)

Type Professional's Name Date

_____

_____

_____

_____

_____

_____

_____

III. Birth History

1. Were there problems or complications during pregnancy, delivery, or after birth?: ___Yes ___ No

   Please describe: _____

   _____

2. How many weeks old was your child when born (was birth early or late?)_____

3. At birth, were there inductions? ___Yes ___No At birth, were forceps/suction/vacuum used? ___Yes ___No

4. Was there a C-section? ___Yes ___No If yes, was it planned? ___Yes ___No

5. At birth, were there any complications such as:

   Breech (feet first) ___Yes ___No Difficulty breathing ___Yes ___No

   Fractures ___Yes ___No Jaundice ___Yes ___No

   Bruising ___Yes ___No Cord around neck ___Yes ___No

6. Was child in intensive care or hospitalization after birth? ___Yes ___No If yes, for how long?_____

7. Was your child adopted? ___Yes ___No If yes, child's age at adoption_____

   If yes, adoption was: ____Domestic _____International: what country_____

   Please identify any important details of adoption, adjustment to new home, particular challenges with adoption, etc.

   _____

   _____

   _____

   _____

IV. Childhood and Developmental History

1. Did child crawl? ___Yes ___No If yes, did child crawl with knees off the floor? ___Yes ___No

   If yes, was crawling phase brief? ___Yes ___No Did child drag a leg? ___Yes ___No

   Did child scoot instead of crawl? ___Yes ___No Did child slide? ___Yes ___No

2. Is child toilet trained in bowel and bladder? ___Yes ___No Does child have accidents? ___Yes ___No

3. Please give approximate ages when milestones were met, or comment on anything unusual

   Roll over_____ Crawl_____ Chew solid food_____ Say words_____

   Sit alone_____ Walk_____ Drink from cup_____ Say sentences_____

4. Is there difficulty with: ___ falling asleep ___ staying asleep ___ frequent night waking

5. How does child calm/soothe self? _____

_____

_____

V. Primary Movement Patterns:

Please mark any items below that fit with your child.

Hands Supporting

_____ Frequent injuries with falls (doesn't put hand out to protect face)
_____ Lack of body and space awareness/boundaries
_____ Poor social boundaries (aggressive, standoffish, isolated, easily becoming a victim, bully or being bullied)

Babkin

_____ Tongue out of mouth or mouth movements when using hands
_____ Biting clothing or objects
_____ Nail biting

Babinski

_____ Difficulties with fine motor coordination
_____ Difficulties with gross motor coordination
_____ Poor balance
_____ Poor running or skipping
_____ Trips easily, clumsiness
_____ Walks on inside of feet
_____ Walks on outside of feet
_____ Walks on toes
_____ Walks with toes inward
_____ Walks with toes outward

Foot Tendon Guard

_____ Difficulty standing
_____ Improper crawling
_____ Poor coordination for climbing
_____ Poor coordination for jumping
_____ Poor coordination for running
_____ Poor grounding and stability
_____ Poor walking pattern

Leg Cross Flexion Extension

_____ Difficulty balancing on each foot
_____ Difficulty coordinating legs to ride a bicycle
_____ Hesitant when going down or climbing stairs
_____ Poor coordination across the middle of body
_____ Postural problems

Moro

_____ Becomes overly excited after movement activities
_____ Breath holding with effort
_____ Fearful of feet leaving ground
_____ Hypersensitivity to movement (i.e. does not like head tipped backwards)
_____ Motion sickness
_____ Poor balance, motion sickness
_____ Shallow breath patterns
_____ Seeks intense movement frequently

Fear Paralysis

_____ Difficulty completing tasks when sounds are Nearby
_____ Excessive reaction to touch
_____ Has difficulty completing task with sounds nearby
_____ Hears sounds others do not hear
_____ Hypersensitivity to sounds
_____ Hypersensitivity to touch
_____ Hypersensitivity to visual information
_____ Overly sensitive to loud noises
_____ Visually distracted

Symmetrical Tonic Neck Reflex

_____ Bumps into objects/people frequently
_____ Can't move hands, arms, head separately
_____ Difficulty visually tracking objects
_____ Discomfort and fatigue sitting with arms/legs bent or standing with arms/legs straight
_____ Difficulty sitting in chair for period of time; sitting on feet, feet wrapped around chair legs, etc.
_____ Keeps eyes too close to paper
_____ Moves as one unit
_____ Prefers sedentary play
_____ Problems with athletics
_____ Avoids new physical challenges
_____ Puts head down when drawing, reading, writing

Spinal Galant

_____ Discomfort with tight fitting clothing or clothing waistbands
_____ Bladder accidents
_____ Hyperactivity
_____ Poor gross motor coordination
_____ Tends to adjust body/fidget frequently when sitting in a chair
_____ Falls off chair

Spinal Perez

_____ Sound hypersensitivity
_____ Bed wetting
_____ Delayed crawling and walking, difficulty with walking pattern
_____ Difficulty with potty training/bed wetting
_____ Has difficulty controlling movements (too fast/slow, too hard/soft)
_____ Leans on people/objects for stability
_____ Plays roughly with people/objects
_____ Touch hypersensitivity

Asymmetrical Tonic Neck Reflex

_____ Difficulty following verbal directions
_____ Difficulty sequencing events
_____ Difficulty with attention, focus, memory
_____ Does not consistently respond to his/her name
_____ Frequently asks for repetition of directions/verbal Information
_____ Letter/number/word reversals
_____ Lack of hand dominance
_____ Says "what?" or asks for repetition
_____ Difficulty turning, rotating or twisting the body
_____ Difficulty with handwriting
_____ Difficulty throwing and catching
_____ Sound sensitivity

VI. School:

1. If in school, are there difficulties at school with any of the following?

____Reading ____Math ____Spelling ____Getting along with peers
____Handwriting ____Organizing work ____Remembering information ____Restlessness
____Finishing tasks ____Paying attention ____Following directions ____Social skills

2. Are there any problems with coloring, cutting, or using materials with hands?_____

_____

3. If in preschool or daycare are there any difficulties learning colors, letters, numbers, sitting in circle time, peer relationships, and/or beginning reading work (as appropriate for age of child)? Please circle. _____

_____

4. Are there any specific problems?_____

_____

5. Does child receive special services at school, have an Individual Education Plan (IEP) or a 504 plan? ___Yes ___No

If yes, please describe:_____

_____

_____

_____

_____

VII: General:

What are your concerns, needs, or goals for therapy?_____

_____

_____

_____

_____

_____

_____

VII. Sensory Processing Checklist:

Please check off the answer that most fits the child's responses and make comments if you would like. Some questions may not apply

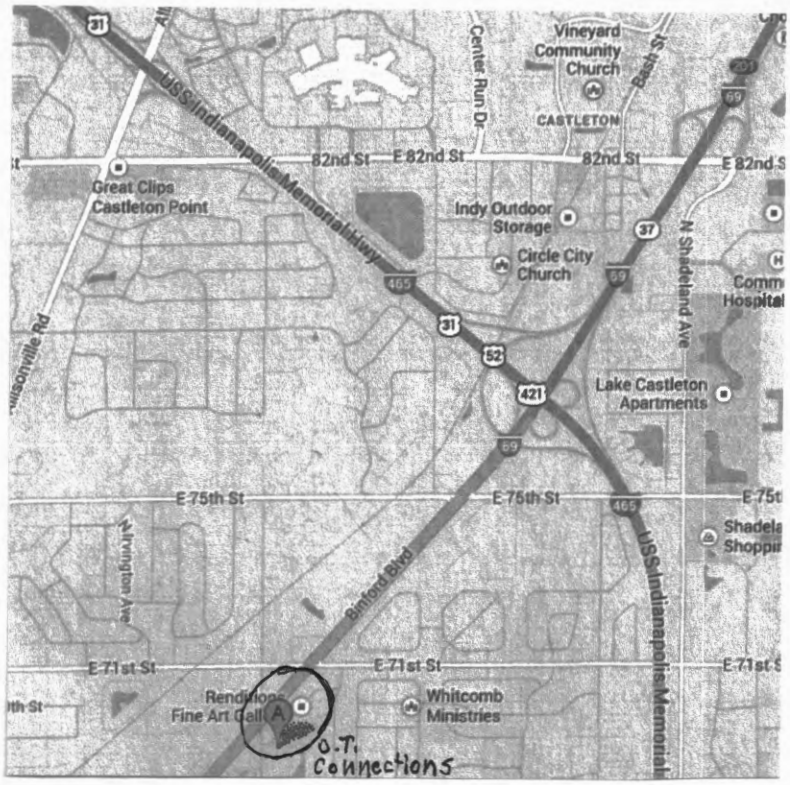
TOUCH (TACTILE) PROCESSING: Does child:	Often	Some-times	Rarely/ Never	Comments
1. feel bothered if socks are not on correctly?				
2. strongly dislike showers?				
3. dislike having arms or back stroked?				
4. seem bothered by wet clothes?				
5. bang head, bite or pinch self?				
6. dislike waistbands in pants or tights?				
7. seem bothered by hair care (comb, brush, shampoo hair)?				
8. seem excessively ticklish?				
9. become irritated by tags in the back of shirts?				
10. prefer to touch rather than be touched?				
11. dislike haircutting or shampooing?				
12. dislike nail cutting?				
13. dislike certain clothing material?				
14. avoid getting hands into messy things?				
15. tend to be more sensitive to pain than others?				
16. notice irritating bumps on the bed sheets?				
17. crave being held or cuddled?				
18. chew or lick on non-food items?				
19. become angry/annoyed when bumped or pushed unexpectedly?				
20. have a high tolerance to pain?				
21. dislike going barefoot on grass, sand, carpet, or dirty floor?				
22. engage in activities that would typically be painful to others.				
23. tend not to feel pain as much as others?				
24. seem oblivious of bruises and heavy falls?				
25. have difficulty finding objects in pockets without looking?				
26. feel bothered by a haircut, shampooing, or drying hair?				
27. feel bothered by brushing or flossing teeth?				
28. chew or bite nails, or grind teeth?				
29. have difficulty noticing food on face?				
30. feel bothered by twisted seams in clothes?				

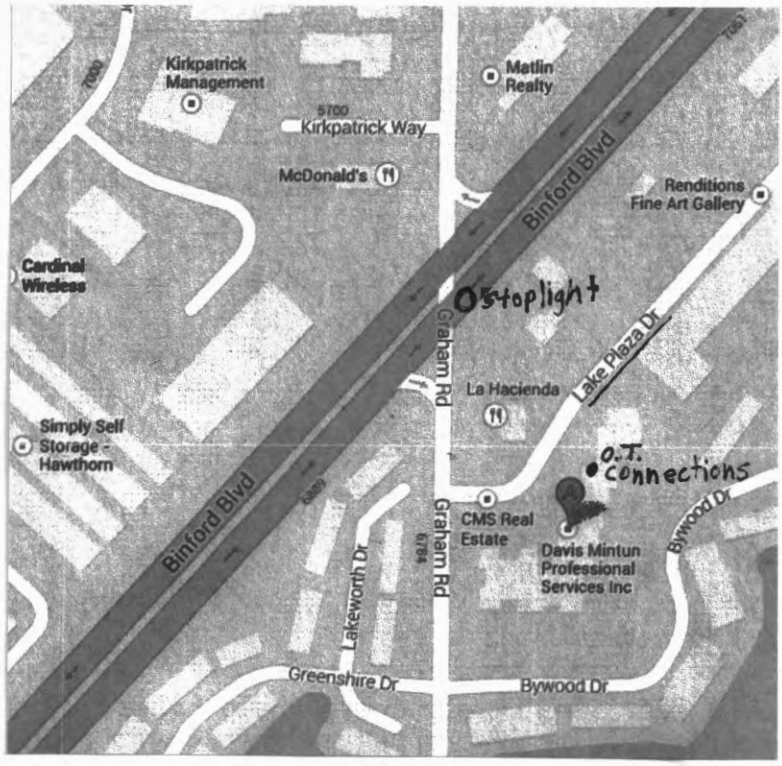
VISUAL PROCESSING: Does child:	Often	Some-times	Rarely/ Never	Comments
1. have difficulty learning colors, shapes, or sizes?				
2. have difficulty/slow to learn letters or numbers?				
3. have difficulty or slow to learn reading?				
4. draw some numbers and letters backwards?				
5. skip letter, words, or lines of text when reading?				
6. complain of headaches when reading?				
7. blink at bright lights or feel irritated by them?				
8. become easily distracted by visual stimulation?				
9. avoid or have difficulty with eye contact?				
10. have trouble following objects with eyes?				
11. close one eye or tilt head when reading?				
12. have difficulty copying from the board to paper?				
13. mistake words with similar beginnings?				
AUDITORY PROCESSING: Does child:	**Often**	**Some-times**	**Rarely/ Never**	**Comments**
1. have speech or articulation difficulties?				
2. bothered or distracted by sounds: toilet flushing, public hand dryers, door slamming, baby crying, dog barking, telephone ringing, sirens/alarms, lawnmowers, nail filing, blender, vacuum, hair dryer, hair dryer, coffee grinder, fireworks ***Please mark any that apply***.				
3. bothered or distracted by background sounds: whispering, radio/TV, refrigerator, fluorescent lights buzzing, talking, clock ticking, fans, water dripping, utensils against each other (spoon in bowl) ****Please mark any that apply.***				
4. bothered by sounds in certain places: crowds, concerts, movies, malls, restaurants, cafeterias, gymnasiums, parties, sporting events, parties****Please mark any that apply.***				
5. receive special services related to hearing or language (speech therapy, etc.)				
6. have difficulty following two or three verbal directions given at once?				
7. misunderstand the meaning of “up”, “behind”, “under”, “on your back”?				
MOVEMENT PROCESSING: Does (or is) child:	**Often**	**Some-times**	**Rarely/ Never**	**Comments**
1. get uncomfortable or vomit from movement activities (merry-go-rounds, swings, car rides)?				
2. seek activities where head is upside down or shakes head?				
3. have difficulty walking on open stairs or going down stairs?				
4. have difficulty with sudden starts or stops in the car?				
5. have difficulty on escalators or elevators?				
6. fear heights or seem fearful if feet are off the floor?				
7. rock in seat or bed?				
8. seem clumsy or accident-prone?				

MOVEMENT PROCESSING: Does (or is) child:	Often	Some-times	Rarely/ Never	Comments
9. walk on toes?				
10. move in and out of the chair?				
11. bump into objects frequently?				
12. have difficulty sitting still in a chair?				
13. over or under-estimate the amount of force needed for a task?				
14. tend to spill or drop things?				
15. dislike going on swings?				
16. avoid fast carnival rides that spin or go up and down?				
17. avoid roller coasters?				
18. like to spin self around?				
19. not seem to become dizzy?				
20. have difficulties with balance?				
21. seek excessive movement?				
22. seem to deliberately fall or tumble?				
23. a "daredevil" or unaware of safety concerns with movement?				
24. avoid activities where head is upside down?				
MOTOR SKILLS: Does child:	**Often**	**Some-times**	**Rarely/ Never**	**Comments**
1. have poor or awkward pencil grasp?				
2. experience fatigue in hand with writing?				
3. have difficulty with handwriting?				
4. have difficulty performing fine motor tasks?				
5. have difficulty handling eating utensils?				
6. seem reluctant to participate in sports/games?				
7. have difficulty learning new motor activities (dance steps, sports)?				
8. have difficulty following the steps when putting something together?				
9. have difficulty learning to ride tricycle or bike?				
10. have difficulty catching balls?				
11. have difficulty tying shoe laces?				
12. approach new motor activities cautiously?				
13. avoid /have difficulty drawing or coloring?				
14. avoid/have difficulty cutting with scissors?				
15. have difficulty pumping self on swing?				
16. have difficulty swimming using the crawl or other strokes?				
17. have difficulty performing tasks in sequence?				
18. have difficulty with motor tasks that have several steps?				
19. tend to be slow in dressing or eating?				

MOTOR SKILLS: Does child:	Often	Some-times	Rarely/ Never	Comments
20. have difficulty cutting with a knife?				
21. plays the same activities over and over				
GENERAL / EMOTIONAL / SOCIAL: Does child:	**Often**	**Some-times**	**Rarely/ Never**	**Comments**
1. seem overloaded by environmental stimulation?				
2. seem to be on sensory overload frequently?				
3. have strong outbursts of anger or emotions?				
4. have difficulty calming self when upset ?				
5. tend to startle easily?				
6. have difficulty engaging in group activities?				
7. have difficulty with social skills?				
TASTE AND EATING: Does child:	**Often**	**Some-times**	**Rarely/ Never**	**Comments**
1. have difficulty with foods having textures: slimy, smooth, soft, lump, or meats? (please circle)				
2. have difficulty eating smooth foods with a few lumps (e.g., soup, mashed potatoes)?				
3. have difficulty with foods mixed together (casseroles, soups, etc.)?				
4. have difficulty with chewy or crunchy foods?				
5. have difficulty eating new or unfamiliar foods?				
6. gag or choke with certain food (please circle)				
7. seem to be a “picky eater”?				

Occupational Therapy Connections
6801 Lake Plaza Drive, Suite A101a
Indianapolis, IN 46220 (317) 581-1185





1. From 465 on the north side of town:
   - On 465 heading east, go 1 exit past Allisonville Rd. to Binford Blvd. exit.
     - Take Binford Blvd. exit and you will go south on Binford Blvd. past stoplights at 75th St. and 71st St . to the stoplight at Graham Rd. See # 3 below.
   - If heading west on 465, take the I-69 exit north to the first exit which is 82nd St.
     - If you continue going straight when you exit I-69 you will be on Shadeland Ave.
     - You will take Shadeland south to 71st St. and turn right on 71st St.
     - Turn left at the stoplight for Binford Blvd. until you get to the stoplight at Graham Rd. See # 3 below.
2. If going north on Binford Blvd.
   - Go past the stoplight at 65th St. to the next stoplight which is Graham Rd. See #3 below.
3. Once you are at Graham Rd.:
   - When you are at the intersection at Graham Rd. and Binford Blvd. you will turn east on Graham Rd.
   - You will see a sign that says Avalon Crossing. Turn left at that sign which is Lake Plaza Dr. then turn right at the first drive into the Lake Plaza office buildings.
   - Our clinic is in Suite A101a and will be one of the first buildings: Building A.