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 you. As part of that process, we ask that you fill out the enclosed questionnaire which will provide information about the patient's 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.

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

- ***Eyeglasses:*** If the patient wears eyeglasses, please bring them to the evaluation.

- ***Doctor's Referral****:* If you are requesting the referral from your 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 the patient 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.

- 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: Teenagers and Adults

Date_____

I. General Information

Patient Name:_____
(first) (last)

Guardian Name: (if a minor)_____
(first) (last)

Birth Date:_____ Email Address:_____ Gender: Male_____ Female_____

Address:_____ City/State/Zip:_____

Phone Numbers (home, work, cell):_____

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

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

Work or School Attended: _____

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:_____

Date of recent vision test and results _____

Date of recent hearing test and results _____

Height _____ Weight _____

Has the patient 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 the patient has received (psychologist, PT, neurologist, OT, etc.)

Type Professional's Name Date

_____

_____

_____

_____

_____

Are there any medical precautions the therapist should be aware of?_____

If there has been any emotional or physical trauma you may describe if you wish:_____

_____

III. Birth History

1. Did the patient's mother have problems or complications during pregnancy, delivery, or after birth?: ___Yes ___ No

   Please describe: _____

   _____

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

3. 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 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. After birth was there hospitalization? ___Yes ___No If yes, for how long?_____

7. Was the patient adopted? ___Yes ___No If yes, at what age was the patient adopted_____

   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 the patient crawl? ___Yes ___No If yes, did child crawl with knees off the floor? ___Yes ___No

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

   Did the patient scoot instead of crawl? ___Yes ___No Did the patient slide? ___Yes ___No

2. 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 the patient calm/relax? _____

_____

_____

V. School / Work / Driving

1. Are there any problems at school or work with any of the following?

____Reading	____Math	____Spelling	____Restlessness
____Handwriting	____Organizing work	____Remembering information	
____Finishing tasks	____Paying attention	____Following directions	

2. Are there any specific problems at work or school?_____

_____

_____

_____

3. Are there any difficulties with driving? If so, please describe:_____

_____

_____

VI. Primary Movement Patterns: Please mark any items below that fit with the patient.

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
_____ Poor coordination for climbing
_____ Poor coordination for running
_____ 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
_____ Moves as one unit
_____ Difficulty visually tracking objects
_____ Discomfort and fatigue sitting with arms/legs bent or standing with arms/legs straight
_____ Puts head down when drawing, reading, writing
_____ Keeps eyes too close to paper
_____ Difficulty sitting in chair for period of time; sitting on feet, feet wrapped around chair legs, etc.
_____ Problems with athletics
_____ Avoids new physical challenges

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
_____ Bladder accidents
_____ Delayed crawling and walking, difficulty with walking pattern
_____ Touch hypersensitivity
_____ Has difficulty controlling movements (too fast/slow, too hard/soft)
_____ Leans on people/objects for stability
_____ Plays roughly with people/objects

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
_____ Sound sensitivity
_____ Difficulty turning, rotating or twisting the body
_____ Difficulty with handwriting
_____ Difficulty throwing and catching

VII: General:

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

_____

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VIII. Sensory Processing Checklist:

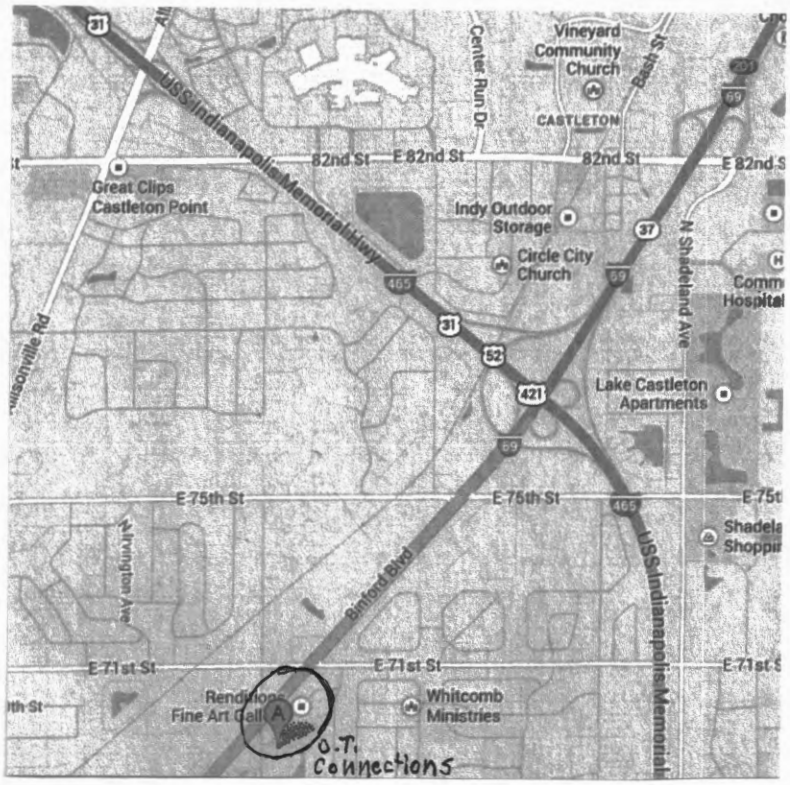
Please check off the answer that most fits the patient's responses and make comments if you would like. Some questions may not apply.

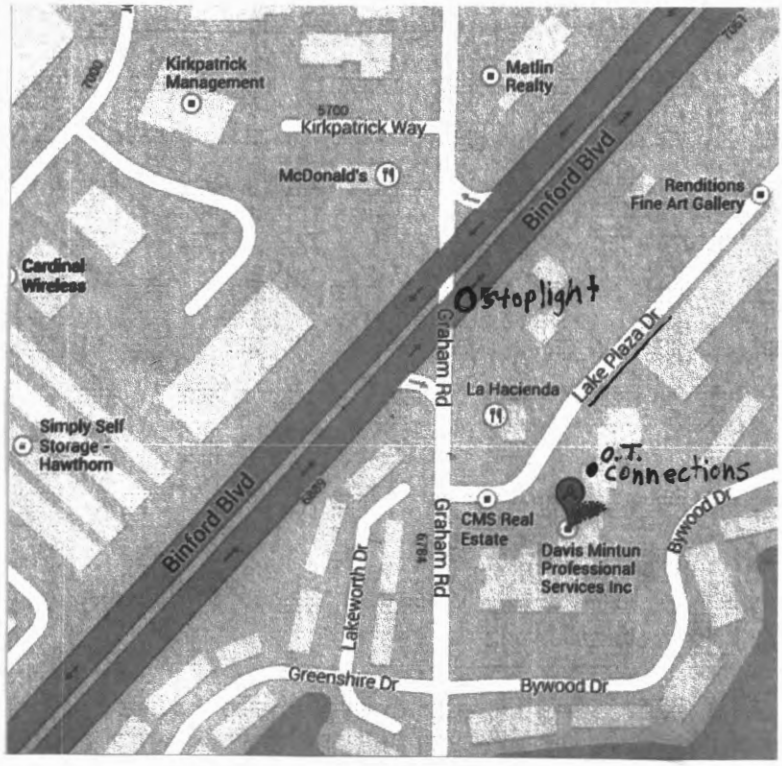
TOUCH (TACTILE) PROCESSING: Does the patient:	Often	Some-times	Rarely/ Never	Comments
1) feel bothered if socks are not on correctly?				
2) strongly dislike showers?				
3) dislike having arms or back stroked?				
4) seem bothered by wet clothes?				
5) bang head, bite or pinch self?				
6) dislike 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) have a high tolerance to pain?				
20) dislike going barefoot on grass, sand, carpet, or dirty floor?				
21) engage in activities that would typically be painful to others.				
22) tend not to feel pain as much as others?				
23) seem oblivious of bruises and heavy falls?				
24) have difficulty finding objects in pockets without looking?				
25) feel bothered by a haircut, shampooing, or drying hair?				
26) feel bothered by brushing or flossing teeth?				
27) chew or bite nails, or grind teeth?				
28) have difficulty noticing food on face?				
29) feel bothered by twisted seams in clothes				

VISUAL PROCESSING: Does the patient:	Often	Some-times	Rarely/ Never	Comments
1) draw some numbers and letters backwards?				
2) skip letter, words, or lines of text when reading?				
3) complain of headaches when reading?				
4) blink at bright lights or feel irritated by them?				
5) become easily distracted by visual stimulation?				
6) avoid or have difficulty with eye contact?				
7) have trouble following objects with eyes				
8) have difficulty following traffic signs while driving?				
9) see double?				
10) closes one eye or tilts head when reading?				
AUDITORY PROCESSING: Does the patient:	**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) the patient:	**Often**	**Some-times**	**Rarely/ Never**	**Comments**
1) dislike flying in airplanes?				
2) become carsick easily?				
3) become upset if head is tilted backwards as in hair washing?				
4) have difficulty driving through tunnels or over bridges?				
5) have difficulty on escalators or elevators?				
6) fear heights, have difficulty on ladder?				
7) have difficulty if not in the front seat while riding in a car?				
8) have difficulty driving or merging while driving onto a freeway				
9) have difficulty or hesitation going up or down stairs?				
10) have difficulty walking on open stairs?				
11) rock in seat?				

MOVEMENT PROCESSING: Does (or is) the patient:	Often	Some-times	Rarely/ Never	Comments
12) walk on toes?				
13) find exercise or physical activity organizing when stressed or upset?				
14) move in and out of your chair?				
15) bump into objects frequently?				
16) seem clumsy or accident-prone?				
17) have difficulty sitting still in a meeting or class ?				
18) over or under-estimate the amount of force needed for a task?				
19) tend to spill or drop things?				
20) have difficulty walking on open stairs or going down stairs?				
21) have difficulty with sudden starts or stops in the car?				
MOTOR SKILLS: Does the patient:	**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. have difficulty learning new motor activities (dance steps, sports)?				
7. have difficulty following the steps when putting something together?				
8. have difficulty catching balls?				
9. approach new motor activities cautiously?				
10. have difficulty performing tasks in sequence?				
11. have difficulty with motor tasks that have several steps?				
12. have difficulty cutting with a knife?				
GENERAL / EMOTIONAL / SOCIAL: Does the patient:	**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?				

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.