OTA Wakefield
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Developmental/Sensory History Questionnaire

TODAY'S DATE:

CLIENT INFORMATION:	
Child's Full Name:	**Nick Name: (if applicable)**
Date of Birth:	**Current Age:**
Home Address:	**Home Phone Number:**
Primary Care Doctor:	**Email Address of Parent:**

MEDICAL DIAGNOSIS:				
□ Autism Spectrum Disorder	□ PDD-NOS	□ Asperger's Syndrome	□ ADD/ADHD	□ Nonverbal Learning Disability
□ Learning Disability	□ Developmental Delay	□ Dyslexia	□ Cerebral Palsy	□ Congenital Anomaly Please specify:
□ Other:				

MEDICAL HISTORY:	Comments:		Comments:
□ Allergies		□ Asthma	
□ Seizures		□ Ear Infections	
□ Diet Restrictions		□ Orthotics/Braces	
□ Major Illness		□ Low/High Birth Weight	
□ Ear Tubes		□ Hearing Loss	
□ Anxiety		□ Visual/Ocular Motor Issue	

□ GI Issues		□ Breathing Difficulties	
□ Torticollis		□ Other:	

DAYCARE/SCHOOL:

Child's Current Daycare/School:	**Hours Per Week:**
Classroom Type: (if applicable) □ Traditional □ Integrated □ Separate	**Adult/Child Ratio: (if known)**

Difficulties Noted:	□ Paying Attention □ Playing with Peers □ Following Directions □ Hyperactivity □ Finishing Work □ Organization □ Other:

FAMILY INFORMATION:

Parent # 1:	**Parent # 2:**
Name:	Name:
Profession:	Profession:
Contact Number:	Contact Number:
Email Address:	Email Address:

Siblings:		Any diagnosis, delays, or difficulties?
Name:	Age:	□ No □ Yes Please Specify:
Name:	Age:	□ No □ Yes Please Specify:
Name:	Age:	□ No □ Yes Please Specify:

CURRENT MEDICATIONS:

Medication:	Purpose of Medication:	Frequency of Dosage:	Side Effects: i.e. Any change in arousal level? Does medication wear off?

EVALUATIONS & SERVICES:

Type:	Evaluation Date:	Treatment Dates:	Findings/ Outcome:
Neurological			
Neuropsychological			
Occupational Therapy			
Speech & Language			
Physical Therapy			
Vision Therapy			
Psychological			
Audiology			
Applied Behavioral Analysis			
Social Skills			
Nutrition			
Gastrointestinal			
Pulmonology			
Ear, Nose, & Throat			
Swallow Study			

SPEECH & LANGUAGE:

Which does your child use to currently communicate? □ Speech □ Pointing □ Vocalizations □ Facial Expressions

□ Pictures □Gestures □ Augmentative Device □ Sign Language

PRENATAL HISTORY:

Did the mother experience any of the following during pregnancy:

	Description:		Description:
□ Infection		□ Bed Rest	
□ Significant Illness		□ High Blood Pressure	
□ Unusual Stress/Shock		□ Gestational Diabetes	
□ Premature Labor		□ Depression	

Medications Taken During Pregnancy:

BIRTH HISTORY:			
Birth Weight of Child:		Country of Birth:	
Is your child adopted? □ Yes □ No		Age Adopted:	
Country of Adoption:		Conditions Prior to Adoption (if known):	
Did your child experience any of the following complications?			
	Comments:		Comments:
□ Premature Birth # Weeks Premature: _____		□ Additional Hospitalization How Long?_____	
□ Drop in Heart Rate		□ Cord Wrap	
□ Small for Gestational Age / IUGR		□ Caesarean Section	
□ Breech Position		□ Jaundice	
□ Forceps Delivery		□ Birth Injuries	
□ Suction Delivery		□ CPAP	
□ Require Ventilation		□ Other:	

INFANCY & EARLY CHILDHOOD:			
Did your child experience any of the following?			
□ Colic	□ "Terrible Twos"	□ Difficulty with transition from baby food to table food	□ Difficulty learning to self-feed
□ Disliked laying on stomach	□ Difficulty Sleeping	□ Episodes of choking, gagging, or vomiting with food	□ Difficulty with breastfeeding
□ Difficulty playing with children	□ Difficulty self-soothing when upset	□ Difficulty with bottle feeding	□ Reflux

DEVELOPMENT:			
Milestone **Comments**		**Age Met**	**Did Not Do**
Roll Over		□	
Sit up (unassisted)		□	
Crawl *Did your child do any of the following types of crawls?* □ Commando □ "Bunny Hop" □ Scoot on Bottom		□	

Walk		□	
Introduced to puree foods		□	
Chew Solid Food		□	
Drink from a Cup		□	
Feed self with utensils		□	
Toilet Trained		□	

TOUCH PROCESSING

How often does your child ***have difficulty*** tolerating the following:

Never	Always	Frequently	Occasionally	Rarely
0 days/week	6-7 days/week	4-5 days/week	2-3 days/week	1 day/week

MODULATION

DRESSING

Tags in the back of shirts					
Seams of Socks					
Wearing Shoes:					
Clothing Textures:					
Jeans					
Corduroy					
Wool					
Tight Clothing					
Loose Clothing					
Other:					
Transitioning to clothes with changes in season					

GROOMING

Washing Hair					
Fingernail Cutting					
Toenail Cutting					
Tooth-brushing					
Hand Washing					
Face Washing					
Blowing Nose					
Ears being cleaned (Q-tip)					
Coming Out of a Bath					

Haircuts					
Dentist					
TEXTURES					
Glue/Paste					
Finger Paint					
Shaving Cream					
Fur					
Sand					
Getting Food on Hands					
Being Splashed with Water					
Band-Aids/Stickers on Skin					
Small Cuts					
Mosquito Bites					
Being bumped/pushed					
Hand being held					
Hugs/Cuddling					
DISCRIMINATION					
How often does your child do the following? **Never**	**Always** 6-7 days/week	**Frequently** 4-5 days/week	**Occasionally** 2-3 days/week	**Rarely** 1 day/week	0 days/week
Have difficulty recognizing food stuck on their face					
Not feel pain as much as others					
Seems oblivious to bruises and heavy falls					
Have difficulty registering the need to eliminate					

PROPRIOCEPTION

Never	**Always** 6-7 days/week	**Frequently** 4-5 days/week	**Occasionally** 2-3 days/week	**Rarely** 1 day/week	0 days/week

MODULATION					
Bang Head on Purpose					

In which situations?					
How long does it last?					
Seek out activities that provide force?					
Jumping					
Pushing					
Pulling					
Other:					
Find physical activity calming when stressed or irritated					
Likes tight clothing/shoes					
Craves being cuddled/held					
Toe Walks					
Does your child engage in any repetitive behaviors?					
Flaps Hands					
Head Banging					
Wrings Fingers					
Bites Self					
Pinch Self					
Mouths Objects					
Touches Objects					
DISCRIMINATION					
Bumps into other objects/ people					
Trips over surface changes					
Falls while sitting/standing					
Misunderstand meaning of words in relation to body position					
Oblivious to bruises/heavy falls					
Difficulty registering the need to eliminate					
Uses too much force to:					
Pet Animals					
Play with Children					
Drink from a Cup					
Write/Color					

Write/Color					
Use Objects/Toys					
Other:					

VESTIBULAR PROCESSING

How often does your child do the following?

	Always	Frequently	Occasionally	Rarely	Never
	6-7 days/week	4-5 days/week days/week	2-3 days/week	1 day/week	0

MODULATION

Hyper-Responsive

Hesitates/Avoids swings					
Hesitates/Avoids slides					
Hesitates/Avoids climbing on jungle gyms					
Hesitates/Avoids descending stairs					
Dislike elevators/escalators					
Avoids merry-go-rounds or rides					
Fearful of heights					
Becomes Carsick					
Unable to provide warning about nausea when on moving equipment					
Becomes suddenly fearful/ frightened during movement and wants to stop					

Hypo-Responsive

Constantly moving					
Difficulty sitting still					
Fidgets while seated					
Seeks spinning movement					
Seeks stimulation on swings					
Runs repetitively					

DISCRIMINATION

Move in a clumsy manner					

Falls when negotiating the environment					
Falls off furniture					
Falls off playground equipment					
Has difficulty standing on one foot					
Moves in/out of chair frequently					

SMELL

How often does your child do the following?

Never	Always	Frequently	Occasionally	Rarely
	6-7 days/week	4-5 days/week 0 days/week	2-3 days/week	1 day/week

Has difficulty tolerating various odors					
Comments on smells					
Has difficulty eating at a restaurant due to smell					
Deliberately smells objects					

EATING/FEEDING

How often does your child do the following?

Never	Always	Frequently	Occasionally	Rarely
	6-7 days/week	4-5 days/week 0 days/week	2-3 days/week	1 day/week

MODULATION

Reacts defensively to foods					
How does your child react to these foods?	☐ Refuses	☐ Spits out	☐ Gags	☐ Chokes	☐ Vomits
Please specify which foods:					
Reacts defensively to textures					
Which food textures?					
React defensively to food colors?					
Which colors?					

Eats a small amount of food					
Fills up quickly					
Never seems to get hungry					
Does not ask for food/drink					
Chews on objects					
Grinds teeth					
Makes mouth noises					
Prefers crunchy foods					
Have difficulty eating mixed textures					
Licks or sucks on non-food items					
Which items?					
How often does your child eat the following tastes/textures:					
Sweet					
Sour					
Salty					
Spicy					
Seeks vibration to mouth (i.e. electric toothbrush)					
Stuffs food into mouth					
Self-feeds with their hands					
Self-feeds with utensils					
DISCRIMINATION					
Eats in a sloppy manner					
Keeps mouth open often					
Drools without noticing					
Pockets food between cheeks/teeth					

AUDITORY

How often does your child do the following?

	Always	**Frequently**	**Occasionally**	**Rarely**	**Never**
	6-7 days/week	4-5 days/week	2-3 days/week	1 day/week	0 days/week

MODULATION

Is your child sensitive to any of the following:

Vacuum					
Blender					
Toilet					
Lawn Mower					
Sirens					
Alarms					
Music					
Car Horn					
Other:					
Is your child distracted by background noises					
Holds hands over ears to protect from sound					
DISCRIMINATION					
Does not seem to hear					
Does not respond to name					
Difficulty remembering what was said					
Difficulty following directions					
Requires frequent repetition of directions					
Has difficulty localizing sound (i.e. turning correctly towards direction of voice/ name/sound)					
Talks excessively loud					
Talks very softly					

VISUAL PROCESSING

How often does your child do the following?

	Always	**Frequently**	**Occasionally**	**Rarely**	**Never**
	6-7 days/week	4-5 days/week days/week	2-3 days/week	1 day/week	0

MODULATION					
How often does your child visually fixate on the following:					
Spinning fans					

Looks at wheels spinning					
Lights					
Reflective objects					
Shadows					
Bright Screens (i.e. computer, TV)					
Stares at walls while walking past them					
Is your child overly sensitive to bright lights?					
Does your child request to wear sunglasses often					
Does your child dislike having their eyes covered					
VISUAL ATTENTION					
Never 0 days/week	**Always** 6-7 days/week	**Frequently** 4-5 days/week	**Occasionally** 2-3 days/week	**Rarely** 1 day/week	
Does your child make eye contact?					
Is your child easily distracted by visual stimuli?					
Does your child look away from the paper when they are engaging in a desk top task					
Does your child look away when catching a ball?					
VISUAL PERCEPTION					
*Does your child **<u>have difficulty</u>** with any of the following:*					
Discriminating shapes					
Discriminating colors					
Doing puzzles					
Copying block designs					
Draws letters/numbers backwards					
OCULAR MOTOR					

	*Does your child **<u>have difficulty</u>** with any of the following:*				
	Always 6-7 days/week	**Frequently** 4-5 days/week	**Occasionally** 2-3 days/week	**Rarely** 1 day/week	**Never** 0 days/week
Following objects with their eyes					
Tracking a ball to catch it					
Copying from paper to paper					
Copying from the blackboard					
Connect-the-dot tasks					
Mazes					
Does your child squint their eyes frequently?					

POSTURAL STRENGTH/ENDURANCE

Does your child exhibit any of the following?

Slump while sitting					
W-Sit when in a kneeled position					
Lean head on hand for support while sitting					
Has difficulty sitting upright on the floor					
Has difficulty sitting upright in a swing					
Falls out of their chair					
Uses wall for support while standing					
Has difficulty laying on their belly					
Tires easily with activity as compared to peers					

FINE MOTOR STRENGTH/COORDINATION

How often does your child do the following?

Always 6-7 days/week **Frequently** 4-5 days/week **Occasionally** 2-3 days/week **Rarely** 1 day/week **Never** 0 days/week

Does your child:

Have a hand preference? ☐RIGHT-HANDED ☐LEFT-HANDED ☐USES BOTH

Seem shaky when doing fine motor tasks?					

Dislike playing with manipulatives (i.e. Legos)					
Experience hand fatigue with coloring/ writing					
Color inside the lines					
Cut with scissors					

GRASP PATTERNS

*Does your child **<u>have difficulty</u>** with any of the following:*

	Always 6-7 days/week	**Frequently** 4-5 days/week	**Occasionally** 2-3 days/week	**Rarely** 1 day/week	**Never** 0 days/week
Turning pages of a book					
Using a fork					
Using a knife					
Holding a crayon/pencil					
Grasping scissors					
Turning a wind-up toy					
Twisting off a cap/top					

HANDWRITING

*Does your child **<u>have difficulty</u>** with any of the following:*

	Always 6-7 days/week	**Frequently** 4-5 days/week	**Occasionally** 2-3 days/week	**Rarely** 1 day/week	**Never** 0 days/week
Writing their name					
Printing upper case letters					
Printing lower case letters					

FASTENERS

Can your child independently:	**Always** 6-7 days/week	**Frequently** 4-5 days/week	**Occasionally** 2-3 days/week	**Rarely** 1 day/week	**Never** 0 days/week
Un-button					
Button					
Un-zipper					

Zipper					
Velcro					
Dress self					
Tie shoelaces					
Buckle					

ORAL MOTOR SKILLS

	Always	Frequently	Occasionally	Rarely	Never
	6-7 days/week	4-5 days/week	2-3 days/week	1 day/week	0 days/week
Can your child:					
Blow soap bubbles					
Stick out their tongue					
Puff out their cheeks					
Blow whistles					
Suck through a straw					

MOTOR PLANNING

How often does your child do the following?

	Always	Frequently	Occasionally	Rarely	Never
	6-7 days/week	4-5 days/week	2-3 days/week	1 day/week	0 days/week
Does your child experience any of the following:					
Perform movements in a slow and plodding fashion					
Require increased time to do motor tasks					
Have difficulty with tasks that have several steps?					
Have difficulty learning new tasks?					
Need motions to be imitated prior to doing?					
Can your child:					
Jump with both feet					
Skip with both feet					
Pedal a tricycle					
Ride a bicycle with training wheels					

Ride a bicycle without training wheels					
Climb on/over objects					
Kick a ball					
Hop on one foot					
Perform jumping jacks					
Jump rope					
Swim					
Walk up stairs					
With two feet on each step?					
With one foot on each step?					
Holding onto a rail/wall/hand for support?					
Walk down stairs					
With two feet on each step?					
With one foot on each step?					
Holding onto a rail/wall/hand for support?					

SCHOOL SKILLS

	Always	**Frequently**	**Occasionally**	**Rarely**	**Never**
	6-7 days/week	4-5 days/week	2-3 days/week	1 day/week	0 days/week
*Does your child **<u>have difficulty</u>** with:*					
Following directions					
Paying attention					
Remembering Information					
Finishing Tasks					
Sitting at a table					
Transitioning between tasks					
Organizing work/materials					

SELF-REGULATION

*<u>**How often**</u> does your child do the following?*	**Always**	**Frequently**	**Occasionally**	**Rarely**	**Never**
	6-7 days/week	4-5 days/week	2-3 days/week	1 day/week	0 days/week

Have outbursts of anger/tantrums?					
How long does a single tantrum last?					
What triggers a tantrum?					
What helps calm them down?					
How often does your child display the following aggressive behaviors:					
Biting					
Hitting					
Kicking					
Pinching					
Other:					
How often does your child display the following:	**Always** 6-7 days/week	**Frequently** 4-5 days/week	**Occasionally** 2-3 days/week	**Rarely** 1 day/week	**Never** 0 days/week
Does your child have a strong desire for routine					
Deals poorly with unstructured time					
Is impulsive					
Is frustrated easily					
Lacks self-confidence					
Tends to crave attention					
Is sensitive to criticism					
Is quiet/withdrawn					
Tends to be stressed					
Tends to be impatient					
Has difficulty separating from parent					
Prefers the company of adults or older kids					

What are your main concerns for your child?

Do any of your child's issues affect your family life? If so, please describe how:

What skills do you want your child to develop?

_____

_____

_____

_____

Does anyone else in your family have similar difficulties to your child's? If so, please describe:

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