



ADVANCE THERAPY

occupational, physical and speech therapy for children

INITIAL EVALUATION QUESTIONNAIRE

DATE: _____

CHILD'S NAME: _____

DOB: _____

AGE: _____

DIAGNOSIS (if any): _____

PARENT/CAREGIVER

NAME(s): _____

Reason for evaluation:

Parental Concerns:

Recommendations from other professionals:

****Please answer the following questions to the best of your ability.***

			Comments
Significant childhood illnesses or injuries?	YES	NO	If yes, please describe:
Has hearing been evaluated?	YES	NO	If yes, when? PE Tubes? YES/NO If yes, when?
Has vision been evaluated?	YES	NO	If yes, does your child wear glasses? YES/NO
Environmental or food allergies?	YES	NO	If yes, please list:
Currently taking any medications?	YES	NO	If yes, please list:
Any dietary restrictions?	YES	NO	If yes, please list:



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How would you describe your child at present: (include behavior, mood, ability to learn new things, attention, ability to calm, strengths, etc.)

Describe your child's likes and dislikes:

How does your child communicate? (Verbal, gesture, pictures, sign, AAC)

If school age, what school does your child attend?

Does your child have an IEP or IFSP? If yes, please attach or briefly describe his/her goals:
If yes, when was last evaluation? _____

Is there a family history of any *related* medical (physical or emotional) conditions?

Do any of your child's siblings receive therapy services?

Has your child previously received or is your child currently receiving therapy? If so, where?



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Please list your desired goals: (e.g. in the next several months I would like my child to...)

Additional comments, questions or concerns?

*When treatment is recommended, we always want to schedule appointments on days and times that work well for you. Evening and weekend appointments are most popular. **Please describe your child's weekly school schedule and your current availability.** Thank you for your flexibility!