Advance Therapy
Occupational, Physical, and
Speech Language Therapy for Children
*"Helping children shine!"*

# INITIAL EVALUATION QUESTIONNAIRE

DATE:_____

NAME OF CHILD BEING EVALUATED:_____

DOB:_____

AGE:_____

DIAGNOSIS (if any):_____

PARENT/CAREGIVER NAME:_____

Reason for evaluation:

Parental Concerns:

_____

_____

Recommendations from other professionals:

_____

_____

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

| **Medical History** | | | **Comments** |
|---|---|---|---|
| Has your child had any significant childhood illnesses or injuries? | **YES** | **NO** | |
| Has your child's hearing been evaluated? | **YES** | **NO** | If yes, when?<br><br>PE Tubes? YES/NO If yes, when? |

| | | | |
|---|---|---|---|
| Does your child have a hearing deficit? | **YES** | **NO** | If yes, please provide test results/audiogram. |
| Does your child have any environmental or food allergies? | **YES** | **NO** | |
| Does your child have a vision deficit? | **YES** | **NO** | |
| Is your child currently on any medications? | **YES** | **NO** | |
| Does your child have any dietary restrictions? | **YES** | **NO** | |

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|---|
| Describe your child at present: (include behavior, mood, ability to learn new things, attention, ability to calm, etc.) |
| Describe your child's likes and dislikes: |
| How does your child make his/her needs and wants known? (Verbal, gesture, pictures, sign, AAC) |
| What school does your child attend? |
| Does your child have an IEP or IFSP? If yes, *please attach* or briefly describe his/her goals: |

| **Family History:**<br>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? |
| Do you currently have any adaptive equipment or therapy supplies at home? |
| Additional comments, questions or concerns. |

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