**Pediatric Hands on Therapy, PC**
**P.O. Box 1471**
**Belmont, NC 28012**
**Phone: 980-320-8275, Fax: 704-973-7862**

# Parent Questionnaire

Patient Information

Name: DOB:

Address:

Phone Number: Parent's Names:

Who lives with child at home?

Does your child attend daycare/school?

If yes please list name/grade/full time or part time:

What is primary language at home?

Pediatrician:

Is your child receiving other services? If yes what and where:

Reason for Referral

Who referred your child for therapy?

What is reason for referral?

Parent Concerns

1. Describe your concerns:

2. Please list your goals or improvements:

Medical History

1. Please list complications with your pregnancy and birth: (Premature? How early? NICU stay?)

2. Please list developmental milestones (rolling, sitting, crawling, walking):

3. Does your child have a medical diagnosis or condition?

Sensory History

1. Does your child object to touching certain textures?

2. Does your child object to having his/her face/hair washed, nails cut or teeth brushed?

3. Does your child object to certain sounds?

4. Does your child object to certain smells?

5. Does your child resist certain foods or textures of food?

6. Would you describe your child as overly active or under active?

Further Information

1. What are your child's interests or favorite things?

2. Do you feel your child has any behavior issues?

3. Please list any other information you feel would be helpful for us to complete an evaluation on your child.