Functional Integrated Therapeutic Services
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New Client Questionnaire

May be shared with:

☐FitsOT ☐FitsPT ☐ABA360 ☐Communication Spectrums

Child's Name: ________________________ Birthdate: ________________Today's Date: _____________

Please check (✓) the column which best describes your child. After each item and category, please write any remarks or comments that you feel may be helpful. Please include child's strengths in comment areas.

Perinatal History (Pregnancy)

During your pregnancy did you experience any of the following? (Please check all that apply)

☐Illnesses
☐Injuries
☐Bleeding
☐Anemia
☐Surgical Operations
☐Hypertension
☐Fainting Spells
☐High Blood Pressure
☐Toxemia
☐Gestational Diabetes
☐List any Medications: ___________________
☐Other: ___________

The pregnancy was:

☐Full Term: Months _________ Birth Weight _________
☐Premature: Months _________ Weeks _________ Days _________

Maternal Age at Delivery: _______ years
Birth Order: ☐1st ☐2nd ☐3rd ☐Other: ___________
Name and age of siblings: ____

Labor Information (Please check one)

☐Normal ☐Prolonged ☐Short

Delivery Information (Please check all that apply)

☐Vaginal ☐Breech ☐Caesarean
☐Forceps used ☐ Medication used during delivery: ____________
☐Other:

Apgar Score:

1 minute __________ 5 minutes __________ 10 minutes ___________

Following delivery did your child experience any of the following?

☐Jaundice
☐Cyanosis
☐Congenital Defects
☐Limpness
☐Stiffness
☐Seizures
☐Apnea/Bradycardia
☐Catheter
☐Difficulty Breathing
☐Intubation
☐Delayed Cry
☐Other: _______________

Was there a need for any of the following?

☐Oxygen/Ventilator ☐Transfusions ☐Tube Feedings ☐Surgery ☐Other: ____________________

Length of stay at the hospital? # of days______ NICU stay? # of days ______

Describe your child as a newborn/infant: (Please check all that apply)

☐Cried a lot, fussy, irritable
☐Non-demanding
☐Alert
☐Quiet
☐Passive

☐Active
☐Liked being held
☐Resisted being held
☐Floppy when held
☐Tense when held

☐Had Regular sleep patterns
☐Had irregular sleep patterns

Infant Feeding

☐Breast Fed If yes, how long? ___________________ Frequency ______________

☐Bottle Fed Type of Formula _____________ Amount _______ Frequency _______

Modifications to Nipple? ☐Yes ☐No

Did the child have a strong suck? ☐Yes ☐No

Did the child spit up frequently? ☐Yes ☐No

Medical History

Has your child experienced any of the following?

☐Chicken Pox
☐High Fevers
☐Mumps
☐Whooping Cough
☐Scarlet Fever
☐Rheumatic Fever
☐Diabetes

☐Lung difficulties
☐Bronchial difficulties
☐Pneumonia
☐Bronchitis
☐Asthma
☐Excessive Vomiting
☐Tuberculosis

☐Meningitis
☐Tonsillitis
☐Sinusitis
☐Cleft Palate
☐Tremors
☐Ear Infections

☐Seizures: When_______________ How often _______________ Medications ______________________

☐Heart defect: Type____________________________Medications_________________________________

☐Heart Surgery to correct defect? Type________________________ Date: _______________

☐Physical Injuries: ____

☐Other Surgeries (Describe): Type________________________ Date: ___________________

Type________________________ Date: ___________________

Type________________________ Date: ___________________

☐Allergies: ____

☐Current Medications: ____

____

____

Client's Name ____________

DOB ____________

Has your child been exposed to:

HIIV virus ☐No ☐Yes Comments: ___________________________

Hepatitis B ☐No ☐Yes Comments: ___________________________

Tuberculosis ☐No ☐Yes Comments: ___________________________

Vision Information

Has your child had an eye evaluation?

☐No ☐Yes Optometrist Name _____________________________ Date of Exam: ____/_____/_____

Ophthalmologist Name _________________________ Date of Exam: ____/____/_____

Vision Therapist Name __________________________ Date of Exam: ____/____/_____

Does your child have a vision challenges? ☐No ☐Yes Describe: ____________________________

Does your child have eye muscle imbalance? ☐No ☐Yes Describe: ____________________________

Does your child wear glasses? ☐No ☐Yes Describe: ____________________________

Does your child?

☐Appear to be happier in the dark

☐Picks up pictures or objects and looks very closely and carefully at them

☐Becomes excited when there is a variety of visual objects

☐Squint often

☐Have difficulty maintaining eye contact with another person

☐Have difficulty visually following an object tossed or rolled towards him/her

☐Shift their head from one side or the other in order to look at something

☐Tend to reach too far or not far enough when playing, eating, etc.

Hearing Information

Has your child had a hearing evaluation?

☐No ☐Yes Doctor Name _____________________________ Date of Exam: ____/_____/______

Does your child?

☐Respond negatively to unexpected noises

☐Respond negatively to loud noises

☐Have difficulty paying attention when other noises are nearby?

☐Miss hearing some sounds

☐Seems confused as to the direction of sounds

☐Seems to enjoy strange noises and/or make loud noises

☐Appears to be hard of hearing

☐Enjoys music

☐Has a diagnosed hearing loss

☐Wears a hearing aid

☐Has difficulty understanding what is said

Does your child have hearing challenges? ☐No ☐Yes Describe: ___________________________

Does your child have a history of ear infections? ☐No ☐Yes Frequency:_________________________

Has your child had ear tubes placed? ☐No ☐Yes Date: _____/______/______

Client's Name ____________

DOB ____________

Medical Examinations

Has your child had any of the following examinations? If so, please give the approximate date and the examining person's name and phone number.

Examination	Date	Treating Physician	Physician's Phone #
Physical Examination			
Neurology			
Pneumogram			
Psychiatry			
Psychology			
Education			
Speech			
Audiology			
Other (e.g. Orthopedist, Podiatrist, Cardiologist):			
Other:			

Developmental History

Please note the approximate age at which age your child did the following:

Rolled over both ways: _______________
Sat Alone: ___________________________
Held Head Up (on stomach): _________
Belly crawled: _______________________
Crawled on hands and knees: _________
Pulled to stand: _____________________
Stood alone: _________________________
Cruised: _____________________________

Walked: ___________________________________
Spoke first word (what was it):
____
Spoke first sentence (what was it):
____
Drank from a cup independently _____________
Used a spoon independently _____________
Feed himself independently _____________

Please check the following Skills that your child can do *independently:*

☐ Dress self ☐Undress self
☐Needs assistance with dressing
☐ Needs assistance with undressing
☐Put on a jacket
☐ Snap ☐ Unsnap
☐ Put shoes on ☐ Correct feet
☐ Tie Shoes
☐ Take shoes off
☐ Bathe Self
☐ Button ☐Unbutton

☐ Zip ☐ Unzip
☐Needs Assistance with bathing
☐ Drink from an open cup
☐ Holds bottle
☐ Cut with a knife
☐ Drink from a straw
☐ Finger feed self
☐ Scoop with a spoon
☐ Use a fork (including stabbing food)

Client's Name ____________
DOB ____________

Is your child fully toilet trained? ☐Yes: Age trained ______ ☐No

Bladder, Daytime only? ☐Yes ☐No

Bowel, Daytime only? ☐Yes ☐No

Feeding

Does your child currently eat?

☐Baby food ☐Mashed Table foods

☐Junior food ☐Table Foods

Does your child object to any of the following?

☐Certain food texture: If yes, explain ____________________

☐Certain tastes: If yes, explain _________________________

Other: ____

Does your child?

☐Act as though all foods taste the same

☐Chews on non-food objects

☐Have unusual craving for certain foods

☐Dislike food of certain texture

Does your child feed themselves? Please describe any difficulties:

☐All of the time ☐Some of the time

☐Most of the time ☐Rarely

Difficulties____

Olfactory (Smell)

Does your child?

☐Explore by smelling ☐React negatively to smell

☐Discriminate odors ☐Ignore unpleasant odors

Gross Motor Development

Foot Dominance: ☐ Right ☐ Left ☐ Unknown

Does your child?

☐Spend time playing while lying on stomach

☐Have generally good posture while standing/sitting

☐Have good balance

☐Appear clumsy, often bumping into things or falling down

Client's Name ___________

DOB ___________

Fine Motor Development

Hand Dominance: ☐ Right ☐ Left ☐ Unknown

Does your child?

☐Manipulate objects easily
☐Have difficulty with paper and pencil activities
☐Have difficulty fastening/unfastening clothes? If yes, what type _______________
☐Shift position constantly while standing
☐Shift position constantly while sitting
☐Have a weak grasp
☐Like puzzles, manipulative toys
☐Appear clumsy when playing with toys
☐Have trouble using scissors

School Performance

Does your child?

☐Have difficulty completing tasks
☐Takes an excessive amount of time to complete homework
☐Appear disorganized
☐Have difficulty organizing multi-step tasks (i.e., book, report)
☐Show immature social interactions
☐Have poor peer relations
☐Follows directions well
☐Stays on task

Additional Comments: ____

____

____

____

Tactile

Does your child?

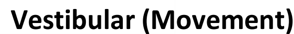
☐Avoid playing with "messy" things (i.e. paint, paste, mud, sand, etc)
☐Dislikes having face washed or wiped
☐Appear to be irritated by cloth or certain textures Specify: _______________________________
☐Object to being touched
☐Dislike being touched unexpectedly
☐Dislike being cuddled
☐Prefer to touch rather than be touched
☐Avoid using hands for extended periods
☐Bangs their head on purpose now or in the past
☐Pinch, bite, or otherwise hurt themselves or others
☐Examine objects by putting them into their mouth
☐Tend to feel pain more or less than others
☐Frequently bump and push other children
☐Dislike hair washing/nail cutting
☐Seem excessively ticklish

Proprioceptive

Does your child?

☐Hold their hands in strange positions
☐Hold their body in strange positions
☐Have awareness of his body in space
☐Have movements that are abrupt and quick in quality
☐Have poor ability to move slowly from one position to another

Client's Name ____________
DOB ____________



Vestibular (Movement)

Does your child?

☐Rock while sitting
☐Jump a lot
☐Like being tossed in the air
☐Seem fearful of movement
☐Seem fearful of space (i.e. going up and down stairs, riding a teeter totter, going through small enclosed spaces)
☐Like merry-go-rounds
☐Spin and whirl more than other children
☐Get car sick
☐Enjoy being rocked now or as an infant
☐Have **no** fear of moving or falling
☐Become irritable during long car rides

Comments:
____
____

Behavior

Your child at present:

☐Is mostly quiet
☐Is overly active
☐Tires easily
☐Talks constantly
☐Very impulsive
☐Is restless
☐Is stubborn
☐Is resistant to change
☐Over reacts
☐Fights frequently
☐Is usually happy
☐Has frequent tantrums
☐Has difficulty separating from primary caretaker
☐Has nervous habits or tics
☐Has short attention span
☐Is easily frustrated
☐Has unusual fears
☐Rocks self frequently
☐Has difficulty learning new tasks (i.e. throwing a ball, building blocks)
☐Makes friends easily:
If no, please describe
____
____
____
☐Engage in unusual or repetitive behavior
☐Difficulty transitioning from one activity to another

Sleep

Does your child sleep well? ☐Yes ☐No Please explain: ________________ Hours per night _____

Does your child take a nap? ☐Yes How long?_______________ ☐No

TV/Games

Amount of exposure to TV/Video Games/Computer per day ______________________________

Family History (*Please indicate if there is a family history of the following):*

☐ Autism
☐Learning Difficulties
☐Substance Abuse
☐Neurological Disorders
☐Mental Illness
☐Speech and Language delays
☐Anxiety disorders

List your child's preferred activities and special interests:

____

____

____

List any significant activities/items that your child dislikes:

____

____

____

Parent Concerns:

____

____

____

Additional Information you may wish to share (include any specific goals or expectations you would like accomplished through therapy).

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DOB ___________