



703-910-5006 [www.CreativeHealthLLC.com](http://www.CreativeHealthLLC.com) [INFO@CreativeHealthLLC.com](mailto:INFO@CreativeHealthLLC.com)

### INITIAL EVALUATION QUESTIONNAIRE

Client's Name: \_\_\_\_\_ Gender: \_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ yrs. \_\_\_ mos. Grade: \_\_\_\_\_

School: \_\_\_\_\_ Teacher: \_\_\_\_\_

Referred by: \_\_\_\_\_

Parent(s): \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: Cell \_\_\_\_\_ Home \_\_\_\_\_ Work \_\_\_\_\_

Email: \_\_\_\_\_ Fax# \_\_\_\_\_

Name of person completing this form: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

### MEDICAL HISTORY

Name of Primary Care Physician & Practice name: \_\_\_\_\_

Physician's Specialty \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Address: \_\_\_\_\_

Date of last examination: \_\_\_/\_\_\_/\_\_\_ Date of next appointment: \_\_\_/\_\_\_/\_\_\_

Current medications and/or remedies prescribed:

1) \_\_\_\_\_ Start Date \_\_\_/\_\_\_/\_\_\_ Purpose \_\_\_\_\_

2) \_\_\_\_\_ Start Date \_\_\_/\_\_\_/\_\_\_ Purpose \_\_\_\_\_

3) \_\_\_\_\_ Start Date \_\_\_/\_\_\_/\_\_\_ Purpose \_\_\_\_\_

Prescribed by: \_\_\_\_\_

Has your child ever been hospitalized? (Circle one) YES NO

Hospital	Month/Year	Reason
_____	___/___	_____
_____	___/___	_____
_____	___/___	_____

Does your child currently have a medical diagnosis? YES NO

If so, please specify: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Was mother's condition during pregnancy good to excellent? YES NO

Were medications taken during pregnancy? YES NO If yes, what? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Were there any complications/illnesses during pregnancy? YES NO

Was the child born within two weeks of the due date? YES NO

Was the child adopted? YES NO

Were labor and delivery normal? YES NO

Was there evidence of injury or poor health at birth? YES NO

Was the child's health during the first month of life good? YES NO

Were there any feeding problems during infancy or as a toddler? YES NO

Does your child have allergies or are allergies suspected? YES NO

Did your child's teeth develop normally? YES NO

Please comment on any of the above areas that you feel were noteworthy: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

As an infant did your child seem.... (circle those that apply)

- ...happy? ...to cry frequently? ...to sleep long hours? ...to wake often?
- ...to feed slowly? ...to eat well? ...to like being rocked? ...to like being held?
- ...colicky? ...difficult to soothe? ...difficult to get to sleep?

Describe any important medical history, chronic ailments, or other health problems that your child has experienced, not listed above: \_\_\_\_\_

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Does your child have any close relatives (father, mother, sister, brother, grandparent) who have similar medical histories? Please list: \_\_\_\_\_

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Please list any other specialists that your child has been seen by for medical, developmental or educational concerns. Please note those that are currently being seen.

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Does your child receive Speech/Language Therapy Services? \_\_\_\_

Name of therapist \_\_\_\_\_ Telephone # \_\_\_\_\_

Does your child receive Physical Therapy Services? \_\_\_\_

Name of therapist \_\_\_\_\_ Telephone # \_\_\_\_\_

Does your child receive Occupational Therapy Services? \_\_\_\_

Name of therapist \_\_\_\_\_ Telephone # \_\_\_\_\_

**FAMILY**

Describe your relationship with your child, currently and in the past:

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Describe your child's relationship with her/his other parent or primary caregiver:

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List names and ages of your child's brothers & sisters:

Name	Age	Relationship (biological, step, half, etc)	Lives with?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Any others living in the home with your child?

Name	Age	Relationship	Grade/Occupation
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Other than those already mentioned, who is in your child's support network?

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### SCHOOL HISTORY

Does your child experience any developmental, academic or behavior problems while in school or daycare, with peers or teachers? (Circle one) YES NO If yes, please explain:

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What is the last year of school your child completed? \_\_\_\_\_

What school is s/he currently attending? \_\_\_\_\_

Is/was your child home-schooled? (Circle one) YES NO. How many years? \_\_\_\_\_

### DEVELOPMENTAL HISTORY

Has your child achieved any of the following sensory-motor milestones? Please state the age if achieved and any comments regarding the quality of their performance.

*Milestone*      *Age/Comments*

Crawling \_\_\_\_\_

Come to sit alone \_\_\_\_\_

Walking \_\_\_\_\_

Using a cup \_\_\_\_\_

Using a spoon \_\_\_\_\_

Chew solid food \_\_\_\_\_

Using crayons \_\_\_\_\_

Using a toilet \_\_\_\_\_

### SPEECH AND HEARING HISTORY

Describe crying in the first year (type, amount) \_\_\_\_\_

At what age (month/year):

First words: \_\_\_/\_\_\_ Examples: \_\_\_\_\_

Two-word phrases: \_\_\_/\_\_\_ Examples: \_\_\_\_\_

Three-word phrases: \_\_\_/\_\_\_ Examples: \_\_\_\_\_

How does your child communicate? (words, sounds, gestures, pointing)

Does your child understand or speak another language besides English? \_\_\_\_

If so, what languages: \_\_\_\_\_

How many words can your child say? \_\_1-10 \_\_10-50 \_\_50-100 \_\_100-300 \_\_300-500

Give a few examples of your child's speech \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you think your child has a hearing problem? \_\_\_ If so, describe \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has your child's hearing been tested? \_\_\_ If so, where \_\_\_\_\_  
Findings? \_\_\_\_\_

Has your child's vision been tested? \_\_\_ If so, where \_\_\_\_\_  
Findings? \_\_\_\_\_

Does your child have any feeding issues? \_\_\_ If so, describe \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe how your child performs and/or feels about performing the following tasks:

Putting on or taking off clothing: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Using arts and craft supplies: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Learning new movements: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Opening containers: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Self-feeding: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Being asked to transition to another activity: \_\_\_\_\_

\_\_\_\_\_

Adjusting to changes: \_\_\_\_\_

\_\_\_\_\_

Writing: \_\_\_\_\_

\_\_\_\_\_

Reading: \_\_\_\_\_

\_\_\_\_\_

Listening to music: \_\_\_\_\_

\_\_\_\_\_

Singing: \_\_\_\_\_

\_\_\_\_\_

If your child exhibits any behavior below, provide age range; describe attempts to alter it.

*Behavior      Age range/Attempts to alter*

Excessive shyness \_\_\_\_\_

Thumb/pacifier sucking \_\_\_\_\_

Difficulty separating from parents \_\_\_\_\_

Face twitching \_\_\_\_\_

Strong fears/nightmares \_\_\_\_\_

Temper tantrums \_\_\_\_\_

Sleep difficulties or bedwetting \_\_\_\_\_

Difficulty sitting still \_\_\_\_\_

Inability to complete activities \_\_\_\_\_

Attention problems \_\_\_\_\_

Non-compliance with routine activities \_\_\_\_\_

## NEURO-PHYSIOLOGICAL STATUS

Please check any of the following disturbances that describe how you believe your child has been feeling lately:

sad    anxious    depressed    frightened    guilty    angry  
 ashamed    aggressive    resentful    worthless    tearful    irritable  
 confused    extreme ups/downs    jealous    hopeless

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Describe any problems which have occurred in your child's life related to trauma, stress and/or abuse: \_\_\_\_\_

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What are your child's sleeping habits like? Include any recent changes.

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What are your child's eating habits like? Include any recent changes.

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What makes your child laugh? \_\_\_\_\_

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What does your child do when angry, frustrated, or overwhelmed?

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How does your child calm him/herself down? \_\_\_\_\_

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Please, briefly, describe any issues or sensitivities your child may have that involve:

Hearing: \_\_\_\_\_

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Touch: \_\_\_\_\_

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Smelling: \_\_\_\_\_

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Mouthing/Eating: \_\_\_\_\_

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Movement: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Vision: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PLAY**

What are your child's favorite toys, activities, or games? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How long does your child play at these favorite activities? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

With whom does your child prefer to play? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does your child play well with other children? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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How does your child play when left alone? \_\_\_\_\_

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### LEVEL OF FUNCTIONING

Please list any accommodations, at home or at school, that your child currently uses to help with participation in daily activities. (visual schedules, sensory diet, equipment, etc.)

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Please describe your child's level of physical activity: \_\_\_\_\_

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How much time every day does your child play on the computer \_\_\_\_\_, watch TV \_\_\_\_\_, or play video games \_\_\_\_\_?

### TREATMENT PLANNING

What do you consider to be your child's greatest strengths? \_\_\_\_\_

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What do you consider to be your child's greatest challenges? \_\_\_\_\_

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Any other comments that might be helpful to us? \_\_\_\_\_

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Would you be interested in speaking with our Pediatric Care Coordinator?

YES NO MAYBE

Please list your therapy goals for your child: \_\_\_\_\_

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Your Name \_\_\_\_\_ Date: \_\_/\_\_/\_\_\_\_

Please provide this information, along with copies of any previous evaluations, educational plans or other reports that you would like the therapist to consider when assessing and treating your child.