OT & Me, LLC
Harrisburg, PA
717.364.4360
OTandMePA@gmail.com

Caregiver Questionnaire

Client Name: _____ DOB: _____

Caregiver completing form: _____ Relationship: _____

Physician: _____ Phone: _____

Medical Diagnosis: _____

Allergies: _____

Surgeries: _____

Medications: _____

Has client had: Vision Screen: YES / NO Hearing Screen: YES / NO

Pregnancy/ Birth complications: _____

_____

_____

School: _____ Grade: _____

Educational Diagnosis: _____ Does client have: 504 or IEP (circle one)

Does student receive services at school? Circle all that apply:

OT	Academic Support	Counseling
SLP	Reading Support	Specialized Classroom: _____
PT	Adaptive Specials	Other: _____

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Teacher expressed concerns or strengths: _____

_____

_____

Clients values, interests, and hobbies: _____

_____

_____

Future or Career Aspirations: _____

_____

_____

Routines (extracurricular activities, sports, etc.): _____

_____

_____

Family goals for client: _____

_____

_____

Reason for seeking occupational therapy services**:** _____

_____

_____

Does client present with any of the following related to VISION (Circle all that apply):

Difficulty Concentrating	Squinting	Covering one eye
Tilting head to read or focus	Excesssive Blinking	Rubbing Eyes

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Using finger to track Guessing at words Omits words

Is client present able to complete the following GROSS MOTOR/ MOBILITY TASKS:

	Yes	No	With Assistance (please explain)
Climb a ladder	_____	_____	_____
Monkey bars	_____	_____	_____
Playground slide	_____	_____	_____
Up and Down Steps	_____	_____	_____
Walk on uneven Surfaces	_____	_____	_____

Is client present able to complete the following SOCIAL/ EMOTIONAL TASKS:

	Yes	No	With Assistance (please explain)
Initiate social interactions	_____	_____	_____
Interact with peers	_____	_____	_____
Interact with adults	_____	_____	_____
Transition between tasks	_____	_____	_____
Respect personal space	_____	_____	_____
Follow Rules	_____	_____	_____
Tolerate losing	_____	_____	_____
Take turns	_____	_____	_____

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Express needs and wants	_____	_____	_____
Describe emotional state	_____	_____	_____
Describe physical state	_____	_____	_____
Tolerate frustration	_____	_____	_____

Does client present with any of the following SELF STIMULATORY BEHAVIORS (Circle all that apply):

Rocking	Staring at Lights	Repetitive Blinking
Hand Flapping	Tapping	Making noises
Scratching or Picking skin	Smelling objects	Chewing on objects

Comments: _____

_____

Is Client able to complete the following SELF HELP SKILLS:

	Yes	No	With Assistance (please explain)
Complete all ADLs	_____	_____	_____
Feed self with utensils	_____	_____	_____
Use an open cup to drink	_____	_____	_____
Open containers	_____	_____	_____
Wash face	_____	_____	_____
Hand and dry hands	_____	_____	_____
Manage clothes for toileting	_____	_____	_____
Maintain toilet hygiene	_____	_____	_____
Button and unbutton	_____	_____	_____
Tie shoelaces	_____	_____	_____

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Zip and unzip hooked zipper _____ _____ _____

Hook or feed a zipper _____ _____ _____

Don and doff coat _____ _____ _____

Fasten snaps _____ _____ _____