



Occupational and Physical Therapy
PARENT CHECKLIST

Dear Parent/Guardian:

Please complete this form thoroughly and return by _____ to _____.
 You may contact _____ if you have any questions. Thank you.

What is school-based occupational and physical therapy?

School-based OT and PT are services that help students benefit from their education. This includes the student's ability to participate in the classroom, lunchroom, recess, gym and other areas of the school.

OCCUPATIONAL THERAPY

Focus is on a student's ability to:

- use classroom tools to produce school work
- follow class routines; organize materials
- perform self-care activities such as hygiene, toileting, feeding and dressing

PHYSICAL THERAPY

Focus is on a student's ability to:

- participate in physical activities within the school
- maneuver within the classroom environment
- access various areas of the school via walking, wheelchair or with other means of mobility

Please check the type of evaluation you are seeking for your child: OT PT

Student's Name:	Home Phone:
Parent/Guardian:	Cell Phone:
Has your child received or is he/she currently receiving: <input type="checkbox"/> OT <input type="checkbox"/> PT If yes, how long?	
Who requested the assessment? <input type="checkbox"/> Myself/Parent <input type="checkbox"/> Doctor <input type="checkbox"/> Teacher <input type="checkbox"/> Other:	
Primary Physician:	Phone #:
Medical Specialist:	Phone #:
Hospital:	Phone #:
Wheelchair/Equipment Clinic:	Phone #:
Orthotist:	Phone #:

Medical Diagnosis: (include allergies) _____

Previous Medical History (include dates)

Surgery: _____ Illness/Hospitalization: _____

Medications: (include supplements or special diet) _____

Was pregnancy and birth typical? Yes No Describe: _____

premature delivery: # of weeks _____

Give approximate age your child was able to:

roll over: _____ sit alone: _____ crawl: _____ walk: _____ say words: _____

How would you describe your child? What are your child's strengths, abilities and interests?

What are your biggest concerns about your child's performance in school?

Describe your child's ability to complete homework. What strategies, if any, do you use?

How do you hope school-based therapy will help your child?

Please check items that apply to your home environment:

- house apartment stairs: # of flights _____ elevator wheelchair accessible

How does your child get to and from school?: walk driven bus/subway other:

What activities does your child participate in outside of school? plays with friends or relatives
 sports or clubs community or social events work or volunteer therapy/medical visits

Please describe:

Please check assistive devices or technology your child uses: switch word processor/laptop

- braces cane crutches walker stander stroller wheelchair other:

Please check items your child can do on his/her own:

- | | |
|--|--|
| <input type="checkbox"/> get in and out of bed | <input type="checkbox"/> use utensils to eat |
| <input type="checkbox"/> stand up from chair or wheelchair | <input type="checkbox"/> drink from a cup |
| <input type="checkbox"/> move around at home | <input type="checkbox"/> make a snack or a sandwich |
| <input type="checkbox"/> make needs known | <input type="checkbox"/> dress <input type="checkbox"/> manage fasteners |
| <input type="checkbox"/> do household chores | <input type="checkbox"/> cross the street |
| <input type="checkbox"/> use stairs | <input type="checkbox"/> take bus or subway |
| <input type="checkbox"/> use bathroom | <input type="checkbox"/> go to store to make a purchase and count change |
| <input type="checkbox"/> manage hygiene/grooming | <input type="checkbox"/> carry item or book bag |

Please check items that apply to your child:

- | | |
|---|---|
| <input type="checkbox"/> weak, tires easily | <input type="checkbox"/> restless, hyperactive |
| <input type="checkbox"/> slow | <input type="checkbox"/> distractible |
| <input type="checkbox"/> clumsy | <input type="checkbox"/> easily frustrated, throws tantrums |
| <input type="checkbox"/> falls down a lot: how often? _____ | <input type="checkbox"/> does not like school |
| <input type="checkbox"/> avoids physical activities | <input type="checkbox"/> difficulty making friends |
| <input type="checkbox"/> mostly watches TV or plays video games | <input type="checkbox"/> struggles to complete assignments |
| <input type="checkbox"/> difficulty going up the stairs | <input type="checkbox"/> doesn't sleep well |
| <input type="checkbox"/> difficulty going down the stairs | sensitive to: |
| <input type="checkbox"/> difficulty walking | <input type="checkbox"/> touch <input type="checkbox"/> sound <input type="checkbox"/> smell <input type="checkbox"/> change in routine |