Office of Dr. Tee Stock New Patient Questionnaire

CONTACT INFORMATION			
Child's Name	Sex	Date of Birth	Age
Parent(s) Name(s)			
Address			
City	State		ZIP Code
Email			
Phone #	Home	Work	Cell
Insurance Company	Policy Number	Subscriber	Subscriber Date of Birth

GENERAL INFORMATION						
Were there any complications, illnesses, or stress during pregnancy?	NO	YES Please Specify				
Were there any complications, during labor or delivery?	NO	YES Please Specify				
What was your child's birth weight?						
Please indicate age/sex of any siblings						
Has your child/ receive Occupational Therapy services in the past?	NO	YES				
		At what age did your child begin therapy?				
		How long did/has your child receive(d) therapy?				
		How frequently was/is your child seen for therapy?				
Has/Does your child/teen receive other interventions? (Circle all that apply)	NO	YES				
		Speech Therapy	Physical Therapy	Applied Behavior Analysis (ABA)	DIR (Floortime)	Other(s):
		How long?	How long?	How long?	How long?	How long?
If the child/teen has a medical diagnosis, please specify:						
Does your child/teen currently take any medications?	NO	YES Please Specify				
Does your child/teen have allergies?	NO	YES Please Specify				
Has your child/teen experienced any major issues or hospitalizations?	NO	YES Please Specify				
Does your child wear glasses?	NO	YES Please Specify Issue(s)				
Does your child have a history of Seizures?	NO	YES Please Specify				

What are your primary concerns?	
What is the hardest time of day?	
How many hours does your child/teen sleep?	
Is your child/teen able to sit during meals?	
Are there any self-care skills you are concerned about?	
If your child/teen is not independent with the bathroom can you remain on site/available?	
Where does your child/teen attend school?	
What are your child/teen's interests/favorite activities?	
Is there anything else you would like to tell me?	