



PERDUEWORKS
THERAPY GROUP

PerdueWorks Therapy Group
2001 N Loy Lake Road Suite J Sherman, TX 75090
(903) 487-5520
426 N Grand Avenue Gainesville, TX 76240
(940) 668-0483

Occupational Therapy Form

PATIENT INFORMATION

Last Name:	First Name:	Middle Initial:
Date of Birth:	<input type="checkbox"/> Male	<input type="checkbox"/> Female

OCCUPATIONAL THERAPY INFORMATION

Reason for visit:
Previous Occupational Therapy Treatment: If yes, where: <input type="checkbox"/> Yes <input type="checkbox"/> No
Describe present problem in detail:
Has there been any significant changes in the last six months?
When were problems first identified? By whom:
How does the present problem interfere with daily function?
Please describe child's strengths and weaknesses:

GOALS

Please list your goals/notes that you would like your child to achieve with the help of therapy:
--

DEVELOPMENTAL CONCERNS:	Yes	No	Sometimes
Will follow your pointing to an item	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Overreacts to noises	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Overreacts to food textures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has difficulty tolerating lights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has difficulty tolerating clothing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has difficulty with baths including washing hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has difficulty playing with children the same age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has difficulty dealing with crowds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has difficulty following several instructions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has difficulty trying or learning new games or activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has difficulty with new foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has difficulty with separation from parents/siblings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has difficulty with transitions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reacts adversely to touch, movement, heights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unusual fear for age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strong interest in letters or numbers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meltdowns that seem to be severe in terms of length > 30 mins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knows age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Responds to name by looking at you more than 1-2 seconds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Follows directions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ADAPTIVE HISTORY:	Yes	No	Sometimes
Feeds self with fingers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeds self with spoon/fork	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uses cup	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing self completely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Undresses partially (shoes, socks)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Undresses independently	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Buttons	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ties shoes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Initiates toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SCHOOL-AGED DEVELOPMENT:	Yes	No	Sometimes
Alphabet mastery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reading speed an issue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reading accuracy an issue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reading comprehension an issue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty with isolated spelling (spelling tests)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Problems with math fact recall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty with word problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>