Cape Kids Therapy & Sensory Center
681 Falmouth Road, Suite D-24
Mashpee, MA 02649
(774) 521-3285

CONTACT INFORMATION				
Child's Name		☐ Male ☐ Female	Date of Birth	Age
Parent(s) Names				
Address				
Email Address				
Telephone	Home	Work	Cell	
School Attending			Grade/Level	
Teacher's Name			School Phone	
Physician's Name and Address Diagnosis			Telephone	

INSURANCE INFORMATION		
Insurance Carrier	Member Name	Member ID

GENERAL INFORMATION			
Were there any complications, illnesses or stress during pregnancy?	☐ Yes ☐ No	Please explain.	
Were there any complications during labor or delivery?	☐ Yes ☐ No		
What is your child's birth order?			
Please specify the condition of your child's birth. Check all that apply..	☐Vaginal ☐Vacuum ☐Premature	☐Forceps ☐C-Section ☐Post mature	☐Post mature ☐Full term
What was your child's birth weight?			
What were your child's Apgar Scores?	At 1 minute		At 5 minutes
Please indicate age/sex of any siblings.			
Has your child received Occupational Therapy services in the past?	☐Yes ☐No	At what age did your child begin therapy?	
		How long did/has your child receive(d) therapy?	
		How frequently was your child seen for therapy?	

Has/Does your child receive other interventions? Check all that apply.	☐ Speech Therapy ☐ Physical Therapy ☐ Applied Behavior Analysis (ABA) ☐ DIR (floor time) ☐ Other (please explain)	How long? How long? How long? How long?
If child has a medical diagnosis, please specify.		
Does your child have a history of ear infections??	☐Yes ☐No	How many? At what ages?
Does your child currently take any medications?	☐Yes ☐No	Please specify.
Does your child have any allergies?	☐Yes ☐No	Please specify.
Has your child experienced any major injuries or hospitalizations?	☐Yes ☐No	Please specify.
Does your child wear glasses?	☐Yes ☐No	
Does your child have a history of seizures?	☐Yes ☐No	Please specify.

Please note the approximate age when you child achieved the following skills?							
	Sitting	Belly crawling	Crawling	Cruising	Walking	First Words	Talking
	Hopping	Jumping	Skipping	Running	Riding a tricycle	Riding a 2-wheel bike	Jump rope

What are your primary concerns?	Please comment.
What is/are the hardest time(s) of day?	Please comment.
Describe the impact on the child and other family members.	Please comment.

SLEEPING

What time does your child awaken?		
What mood is your child in upon morning waking?		
What time does your child fall asleep?		
Does your child have difficulty with sleeping?	☐Yes ☐No	Does your child have trouble falling asleep? ☐ Yes ☐ No Does your child have trouble staying asleep? ☐ Yes ☐ No Does your child have frequent night waking? ☐ Yes ☐ No Do family members have interrupted sleep as a result ☐ Yes ☐ No
How would you rate the severity of sleeping issues?		
How many times does he or she wake?	☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7+	

What does your child do when he/she awakens	☐ Whimpers ☐ Screams ☐ Plays with toys ☐ Goes to parents' bedroom ☐ Puts self back to sleep ☐ Other (please explain)	
What activities do you use to get your child back to sleep? Check all that apply.	☐ Feeding ☐ Holding ☐ Massage ☐ Singing ☐ Rocking ☐ Other (please explain) ☐ Humming ☐ Bouncing	
Describe your routines that are helpful for getting your child back to sleep.		
How old was your child when he/she consistently slept through the night?		
Does your child seem to require too much or too little sleep or at odd times?	☐Yes ☐No	How many hours nightly? What times of day?
Does your child take naps?	☐Yes ☐No	Frequency of naps. Duration of naps. Locations of naps. Does your child need help to fall asleep for naps?
What activities do you use as part of your child's bedtime routine?	☐ Bath time ☐ Singing/Humming ☐ Reading ☐ Holding ☐ Bouncing ☐ Massage ☐ Humming ☐ Bouncing ☐ Rocking ☐ Other (please explain)	
Please describe any necessary specifics regarding bedtime routine.		
What happens if this routine is disrupted?	Impact on child. Impact on family members.	

FEEDING

Was your child breastfed as an infant?	☐Yes ☐No	For how long?
If the child was bottle fed as an infant, were there any difficulties or concerns?	☐Yes ☐No	Please comment.
Did your child have a strong suck as an infant?	☐Yes ☐No	Please comment.
Did your child have problems with appetite or weight gain as an infant?	☐ Yes ☐ No	Please comment.
Did your child have any respiratory problems as an infant?	☐Yes ☐No	Please comment.

Does your child refuse to eat, spit out or gag on foods based on the following	☐Yes ☐No	☐ Temperature ☐ Food texture ☐ Crunchy foods ☐ Chewy foods ☐ Food color ☐ Mixed food textures ☐ Other (please comment)

characteristics? Check all that apply.		
Does your child refuse to eat, spit out or gag on foods based on the following characteristics? Check all that apply.	☐Yes ☐No	☐ Variety of food ☐ Temperature ☐ Food texture ☐ Crunchy foods ☐ Chewy foods ☐ Food color ☐ Mixed food textures ☐Other (please comment)
Does your child have difficulty with ingesting foods? Check all that apply.	☐Yes ☐No	☐ Chewing a variety of foods ☐ Sucking through a straw ☐ Swallowing a variety of foods ☐ Food falling out of mouth ☐ Frequent choking ☐ Managing mixed food textures ☐ Other (please comment)
Is there a disruption in family mealtime as a result of atypical eating patterns	☐Yes ☐No	Please explain.
Does your child exhibit oral motor sensitivities or seeking? Check all that apply	☐Yes ☐No	☐ Examines objects by placing in mouth ☐ Gags/vomits frequently ☐ Bites/chews objects or clothing frequently ☐ Grinds teeth ☐ Other (please comment)
Does your child attempt to eat unusual, noxious or inedible substances or place in mouth?	☐Yes ☐No	Please explain.
Is your child able to sit during meals? Check all that apply.	☐Yes ☐No	☐ 1-2 minutes ☐ 3-5 minutes ☐ 6-10 minutes ☐ Entire Meal Does this impact the quantity of food ingested? ☐Yes ☐No How does this impact harmony at mealtimes?
Where does your child eat meals?	Please specify.	
What routines do you follow that are helpful for getting your child to eat meals?	Please specify.	
What happens if this routine is disrupted	Impact on child. Impact on family members.	

GROOMING

Does your child dislike or resist the tactile feelings of grooming activities? Check all that apply.	☐ Tooth brushing ☐ Bathing ☐ Reading ☐ Hair brushing/combing ☐ Face washing ☐ Haircuts ☐ Nail trimming ☐ Blowing nose ☐ Other (please explain)
Does your child avoid or fear grooming devices? Check all that apply.	☐ Electric toothbrushes ☐ Barber's clippers ☐ Dentistry tools ☐ Other (please explain)
Does your child avoid or fear the sounds associated with grooming activities? Check all that apply.	☐ Hair dryer ☐ Bath water ☐ Hand dryer ☐ Toilet flushing ☐ Other (please explain)
What routines do you follow that are helpful for getting your child to participate in grooming activities?	Please specify.
	Impact on child.

What happens if this routine is disrupted?						
	Impact on family members.					
DRESSING						
Which clothing is your child able to take off independently? Check all that apply.	☐ Shirt	☐ Pants	☐ Underwear	☐ Shoes	☐ Socks	☐ Coat
Which clothing is your child able to put on independently? Check all that apply.	☐ Shirt	☐ Pants	☐ Underwear	☐ Shoes	☐ Socks	☐ Coat
Which fasteners can your child manage independently?	☐ Snaps ☐ Zippers ☐ Buttons (unbutton and button) ☐ Tie shoes Was it a struggle to learn to tie? ☐ Yes ☐ No					
Is your child selective in the types of clothing textures he/she will wear?	☐Yes ☐No	What types of clothing textures are preferred?				
		What clothing textures are avoided?				
Does your child express a need for minimal clothing, regardless of weather?	☐Yes ☐No	Please comment.				
Does your child express a need for clothing to cover entire body or dress in layers, regardless of weather	☐Yes ☐No	Please comment.				
Does your child frequently adjust clothing, as if uncomfortable?	☐Yes ☐No	Please comment.				
Do tags in clothing or seams in socks bother your child?	☐Yes ☐No	What type of reaction/behavior is seen?				
What routines do your follow that are helpful for getting your child to participate with dressing?	Please specify.					
What happens if this routine is disrupted?	Impact on child.					
	Impact on family members.					
TOILET TRAINING						
Is your child currently toilet trained for bladder?	☐Yes At what age? ☐No					
Is your child currently toilet trained for bowel?	☐Yes At what age? ☐No					
Does your child experience urinary and or bowel issues?	☐Yes ☐No	Incontinence during the day	Bedwetting	Constipation	Loose Stools	Lack of Awareness
		How long?	How long?	How long?	How long?	How long?
Does your child wear a diaper or pull-up at night?	☐Yes ☐No					

What routines do you follow that are helpful for getting your child to participate with toileting?	Please specify.	
What happens if this routine is disrupted?	Impact on child.	
	Impact on family members.	
Are you limited in attending family/social gatherings because of your child's behavior or reactivity to events?	☐Yes ☐No	Please comment.
Is your child unable to attend birthday parties?	☐Yes ☐No	Please comment.
Are you unable to leave your child alone with familiar, but not routine, caregivers for children?	☐Yes ☐No	Please comment.
Is your family unable to maintain relationships with other families	☐Yes ☐No	Please comment.
Is your family unable to pursue hobbies and interests?	☐Yes ☐No	Please comment.
Is your child able to tolerate social touch or hugs from others?	☐Yes ☐No	Please comment.
Is your child able to tolerate social touch or hugs from others?	☐Yes ☐No	Please comment.
Does your child have difficulty with different people's voices? Check all that apply.	☐Yes ☐No	☐ Loud voices ☐ Men's voices ☐ Women's voices ☐ Children's voices ☐ Screaming ☐ Crying
What routines do you follow that are helpful for getting your child to participate in social activities?	Please comment.	
What happens if this routing is disrupted	Impact on child.	
	Impact on family members.	
COMMUNITY		
Is your child unable to eat at restaurants?	☐Yes ☐No	Please comment.
Is your child uncomfortable on elevators, escalators or in cars?	☐Yes ☐No	Please comment.
Does your child avoid busy, unpredictable environments?	☐Yes ☐No	Please comment.

Does your child have an excessive reaction to light touch sensation	☐Yes ☐No	What types of reaction/behavior is seen?
Is your child unresponsive to being touched or bumped?	☐Yes ☐No	Please comment.
Does your child have an excessive reaction if bumped unexpectedly?	☐Yes ☐No	Please comment.
Does your child exhibit a lack of safety awareness?	☐Yes ☐No	Please comment.
Does your child have difficulty traveling on a variety of public transportation?	☐Yes ☐No	Please comment.
Does your child have difficulty flying on airplanes?	☐Yes ☐No	Please comment.
Is your child unresponsive to being touched or bumped?	☐Yes ☐No	Please comment.
Is your child able to attend sleepovers?	☐Yes ☐No	Please comment.
Does your child have difficulty with loud crowded sporting events?	☐Yes ☐No	Please comment.
Does your child have difficulty sitting through public performances?	☐Yes ☐No	Please comment.
Does your child have difficulty at sporting events (enclosed or open stadium)?	☐Yes ☐No	Please comment.
Does your child have difficulty in the grocery store?	☐Yes ☐No	Please comment.
Does your child have difficulty in shopping malls?	☐Yes ☐No	Please comment.
Does your child have difficulty with long car rides?	☐Yes ☐No	Please comment.
Does your child have difficulty standing in lines?	☐Yes ☐No	Please comment.

SOCIAL INTERACTION		
Does your child exhibit aggressive behavior?	☐Yes ☐No	Is it directed toward him/herself? ☐ Yes ☐No Is it directed toward others? ☐ Yes ☒No What types of behaviors are exhibited? Check all that apply. ☐ Biting ☐ Pinching ☐ Kicking ☐ Hitting ☐ Other (please explain)
Does your child exhibit tantrums?	☐Yes ☐No	How frequently do they occur? What triggers the tantrums? On average, how long does the tantrum last? Describe strategies that are effective for helping calm your child during a tantrum. Any tantrums a source of distress to other family members? ☐ Yes ☐No
Is your child easily frustrated, anxious or overwhelmed?	☐Yes ☐No	Please comment.
Is your child overly dependent on parent(s) or clingy??	☐Yes ☐No	Are separations challenging? ☐ Yes ☐No
Does your child easily escalate from whimper to intense cry?	☐Yes ☐No	Please comment.
If your child uses atypical repetitive behavior, which behaviors are demonstrated? Check all that apply.	☐ Hand flapping ☐ Rocking ☐ Other (please explain) ☐ Head banging ☐ Jumping ☐ Smelling ☐ Breath holding ☐ Self-talk ☐ Biting ☐ Mouthing objects ☐ Visual fixing ☐ Spinning ☐ Teeth grinding	
Does your child struggle with transition?	☐Yes ☐No	How long does it take to transition on average? What transitions are difficult? What strategies are used to help ease transitions? Does difficult transitioning cause distress to family members? ☐ Yes ☐No Please explain.
Does your child struggle when there is excessive auditory input in his/her environment?	☐Yes ☐No	Please comment.
Does your child struggle around individuals with certain voice pitches?	☐Yes ☐No	Please comment.
Does your child easily escalate from whimper to intense cry?	☐Yes ☐No	Please comment.
Does your child struggle to communicate his/her own needs?	☐Yes ☐No	Please comment.
What is your child's primary form of communication?	☐ Talking ☐ Singing☐ Sounds/vocalizations ☐ Pointing/Gesturing ☐ Crying/Screaming ☐ Other (please explain)	

How often does your child make eye contact during conversation	☐ Less than 25% of the time ☐ 25% of the time ☐ 50% of the time	☐ 75% of the time ☐ 100% of the time
How often does your child orient to his/her name being called?	☐ Less than 25% of the time ☐ 25% of the time ☐ 50% of the time	☐ 75% of the time ☐ 100% of the time
Does your child have difficulty separating for parent or caregiver?	☐Yes ☐No	Please comment.
Does your child appear to have an awareness of others?	☐Yes ☐No	
Does your child appear to have an awareness of self?	☐Yes ☐No	
Does your child lack fear of strangers?	☐Yes ☐No	
How does your child react in new/unfamiliar situations	Please comment.	
Does your child have difficulty paying attention in noisy environments?	☐Yes ☐No	Please comment.
Does your child have difficulty separating for parent or caregiver?	☐Yes ☐No	Please comment.
Does your child avoid maintaining social interaction?	With whom? How often?	
Does your child experience difficulties with language expression? Check all that apply.	☐Yes ☐No	☐ Easily frustrated, anxious or overwhelmed? ☐ Frequently mispronounces words (i.e., bisghetti) ☐ Poor articulation, difficult to understand ☐ Difficulty making choices ☐ Flat, monotonous voice ☐ Hesitant speech ☐ Tendency to stutter ☐ Difficulty expressing emotions verbally
What routines do you follow that are helpful in getting your child to socialize?	Please specify.	
What happens if this routing is disrupted?	Impact on child. Impact on family members.	
PLAY SKILLS/PEER INTERACTION		
How long is your child able to play alone?	☐ 1-2 minutes ☐ 3-5 minutes ☐ 6-10 minutes ☐ 10-30 minutes ☐ 30+ minutes	
What are your child's preferred play activities?	Please comment.	

How much time is spent daily in the following activities?	Passive activities (i.e., TV, computer, etc.)	
	Movement activities (i.e., playground, roughhouse play, etc.)	
	Learning/interactive play	
Is your child destructive towards toys?	☐Yes ☐No	Please comment.
Does your child struggle playing alone (excluding TV watching).	☐Yes ☐No	Please comment.
Does your child struggle playing with other children? Check all that apply	☐Yes ☐No	☐ Parallel play (playing alongside other children) ☐ Interactive play (playing with other children) ☐ Structure group play ☐ Making friends ☐ Pretend play
Is your child preoccupied with seeking intense movement during play? Check all that apply.	☐Yes ☐No	☐ Spinning ☐ Bouncing ☐ Crashing ☐ Jumping ☐ Rocking ☐ Other (please explain)
Does your child have a strong desire for structure or control?	☐Yes ☐No	Please comment.
Does your child struggle to play in familiar settings?	☐Yes ☐No	Please comment.
Does your child struggle to play in unfamiliar settings?	☐Yes ☐No	Please comment.
Which playground equipment will your child play on?	☐ Swings ☐ Slide ☐ Climbing wall ☐ Bridges ☐ Merry-go-round	☐ Ladders ☐ Crawl tunnels ☐ Monkey bars ☐ Spring riders ☐ Other (please comment)	☐ Teeter totter ☐ Crawl tunnels ☐ Vertical climbers
Which playground equipment does your child avoid? Check all that apply?	☐ Swings ☐ Slide ☐ Climbing wall ☐ Bridges ☐ Merry-go-round	☐ Ladders ☐ Crawl tunnels ☐ Monkey bars ☐ Spring riders ☐ Other (please comment)	☐ Teeter totter ☐ Crawl tunnels ☐ Vertical climbers
Does your child avoid certain types of toys (i.e., textured toys)?	☐Yes ☐No	Please comment.
Does your child exhibit poor safety awareness or engage in activities that are potentially dangerous (i.e., jumping without regard)?	☐Yes ☐No	Please comment.

Which of the following "messy" activities does your child avoid?	☐ Sand ☐ Playing in the grass ☐ Finger painting ☐ Play-Doh ☐ Glue ☐ Other(s). Please specify.
Which surface does your child have difficulty with?	☐ Ascending stairs ☐ Descending stairs ☐ Grass ☐ Gravel driveways ☐ Woodchips ☐ Sand ☐ Other(s)
Does your child have poor depth perception (i.e., ducks or blinks when ball is thrown at him/her, difficulty with stairs)?	☐Yes ☐No
Is your child unable to pull up on the monkey bars with bent arms and legs?	☐Yes ☐No
Is your child unable to maintain bent arms and legs while moving bar to bar on the monkey bars?	☐Yes ☐No
Which gross motor skills does your child have difficulty with in comparison to age peers?	☐ Hopping ☐ Jumping ☐ Skipping ☐ Running ☐ Riding a tricycle/bicycle
SCHOOL SKILLS	
Where does your child attend preschool or school?	☐ Homeschool ☐ Daycare ☐ Special needs pre-school class ☐ Regular education class ☐ Glue ☐ Other. Please specify.
Does your child exhibit a hand preference?	☐Yes ☐ Right ☐ Left ☐No Established at what age?
Does your child frequently change his/her grasp on pencils/other tools?	☐Yes ☐No
Which writing skills does your child struggle with/avoid? Check all that apply.	☐ Drawing/coloring ☐ Tracing ☐ Copying ☐ Handwriting ☐ Use of graded pressure ☐ Too much or ☐ Too little ☐ Stabilization of paper while drawing/writing ☐ Proper desk posture
Which fine motor skills does your child struggle with/avoid?	☐ Grasping and maneuvering scissors ☐ Performing two different tasks at the same time (i.e., turn and hold paper while cutting, cut food using knife and fork

Which skills does your child struggle with? Check all that apply.	☐ Finding items within a "hidden picture ☐ Phonetic learning ☐ Telling time ☐ Sequencing months of the year ☐ Puzzles and construction/manipulation of materials ☐ Spelling ☐ Responding promptly to verbal instruction ☐ Writing numbers and letters correctly (without frequent reversals)
Are your child's drawings immature for age?	☐Yes ☐No
Does your child write up/down hill on paper?	☐Yes ☐No
Which of the following visual-related skills does your child struggle with? Check all that apply	☐ Poor eye teaming ☐ Using peripheral more than central vision ☐ Keeping eyes too close to work ☐ Closing/covering one eye while doing near work ☐ Eye strain after reading a short period of time ☐ Reading comprehension ☐ Rereads or skips words ☐ Tracking a moving object with head movement ☐ Copying from chalkboard to paper ☐ Short attention span ☐ Turing head when reading across a page ☐ Losing place often during reading ☐ Needing finger or marker to keep place while reading ☐ Reverses letter or words ☐ Doesn't look when manipulating objects
Does your child have trouble sitting still?	☐Yes ☐No

MOVEMENT SKILLS

Does your child become overly excited after movement activities?	☐Yes ☐No	Please comment
Does your child like to be wrapped tightly in a sheet or blanket or seek tight spaces?	☐Yes ☐No	
Does your child shake head vigorously or assume an upside down position frequently?	☐Yes ☐No	
Is your child able to conceive and organize a plan of action to direct play/movement?	☐Yes ☐No	

Does your child display the following movement difficulties? Check all that apply.	☐ Avoids activities where feet leave the ground ☐ Avoids/fears activities requiring balance ☐ Avoid age appropriate gross motor activities ☐ Excessive dizziness from swinging, spinning or riding in car ☐ Keeping eyes too close to work ☐ Turing head when reading across a page ☐ Closing/covering one eye while doing near work ☐ Losing place often during reading ☐ Eye strain after reading a short period of time ☐ Needing finger or marker to keep place while reading ☐ Reading comprehension ☐ Reverses letter or words ☐ Rereads or skips words ☐ Doesn't look when manipulating objects ☐ Tracking a moving object with head movement	
DAILY ENVIROMENT INTERACTION		
Does your child demonstrate an irrational fear of any of the following noisy appliances? Check all that apply.	☐ Vacuum cleaner ☐ Hair dryer ☐ Fans ☐ Blender ☐ Coffee grinder ☐ Toilet flushing ☐ Dehumidifier ☐ Air vents ☐ Other (please specify)	
Does your child demonstrate an irrational fear of any of the following noisy sounds? Check all that apply	☐ Jets/airplanes ☐ Trucks ☐ Thunder ☐ Other (please specify)	
Is your child confused about the direction of sounds?	☐Yes ☐No	Please comment.
Does your child hear sounds that others do not or before others notice?	☐Yes ☐No	Please comment.
Does your child over ears to shut out objectionable auditory input or overreact to unexpected noises?	☐Yes ☐No	Please comment.
Does your child attend to auditory input less than a few seconds?	☐Yes ☐No	Please comment.
Does your child appear under or over sensitive to pain?	☐Yes ☐No	Please comment.
Does your child dislike having eyes covered or being in the dark?	☐Yes ☐No	Please comment.

Is your child overly sensitive to lights or sunlight?	☐Yes ☐No	Please comment.
Does your child seem to need to "fix" the environment, i.e. arrange objects, chairs, etc.?	☐Yes ☐No	Please comment.
Does your child avoid environments/objects with certain odors?	☐Yes ☐No	Please comment.
Does your child seek environment/objects with certain odors?	☐Yes ☐No	Please comment.

Adapted from: *Listening Skills Inventory*© Vital Links, 2008 and *Sensory History Questionnaire* by Kerry Wallace.