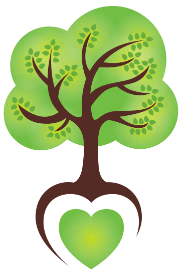

Journeys
Occupational Therapy

Functional Skills Questionnaire

Name	Birth Date	Today's Date
Parent(s) Name		
Person completing this form		
Email		
Phone (Cell)	(H)	(W)

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

SLEEPING	Please add any comments:
What time does your child awaken?	
What mood is your child in upon morning waking?	
What time is your child put to bed?	
What time does your child fall asleep?	
Does your child have difficulty with sleeping including falling asleep, staying asleep and/or frequent nighttime waking?	
Do family members have interrupted sleep as a result?	
How would you rate the severity of sleep issues?	
How many time per night does he/she wake?	

What does your child do when he/she awakens? Mark all that apply.	_____ Whimper _____ Screams _____ Plays with toys _____ Goes to parents' bedroom _____ Puts self back to sleep _____ Other:
What activities do you use to get your child back to sleep? Mark all that apply. Describe your routines that are helpful for getting your child back to sleep:	_____ Feeding _____ Singing _____ Humming _____ Holding _____ Rocking _____ Bouncing _____ Massage _____ Other:
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 (circle one) 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 child need help to fall asleep for naps?
What activities do you use as part of your child's bedtime routine? Mark all that apply.	_____ Bath time _____ Singing/Humming _____ Reading _____ Holding _____ Bouncing _____ Massage _____ Rocking _____ Other:
Please describe any necessary specifics regarding the bedtime routine.	
What happens if this routine is disrupted?	Impact on the child: Impact on family members:

EATING	
How well does your child use eating utensils? Please add any comments here:	____Only eats finger foods ____Prefers finger foods ____Able to spoon appropriate foods: soups, cereal, yogurt, etc ____Able to use a fork with appropriate foods ____Has variable or atypical grasp pattern on utensil ____Has efficient grasp pattern on utensil ____uses a knife to spread foods: i.e. butter, jam, peanut butter ____uses a fork and knife together to cut foods
Does your child refuse to eat, spit out or gag on foods based on the following characteristics? Mark all that apply.	YES / NO Please comment: ____ Variety of food selection ____ Temperature ____ Food texture ____ Crunchy foods ____ Chewy foods ____ Food color ____ Mixed food textures
Does your child have difficulty with ingesting foods? Mark all that apply.	YES / NO Please comment: ____ Chewing a variety of foods ____ Sucking through a straw ____ Swallowing variety of foods ____ Food falling out of mouth ____ Frequent choking ____ Managing mixed food textures
Is there a disruption in family mealtime as a result of atypical eating patterns?	
Where does your child eat meals? Specify.	
Does your child exhibit oral motor sensitivities or seeking? Mark all that apply.	YES / NO ____ Examines objects by placing in mouth ____ Gags/vomits frequently ____ Bites/chews objects or clothing frequently ____ Grinds teeth Other:
Does your child attempt to eat unusual, noxious, or inedible substances or place in mouth? If yes, please comment.	YES / NO Comment:
Is your child able to sit during meals? Does this impact the quantity of food ingested? How does this impact harmony at mealtimes?	____ 1-2 minutes ____ 3-5 minutes ____ 6-10 minutes ____ Entire meal YES / NO Comments:

What routines do you follow that are helpful for getting your child to eat meals?	Specify:
What happens if this routine is disrupted?	Impact on child: Impact on family members:

GROOMING	
Does your child dislike or resist the tactile feeling of grooming activities? Mark all that apply.	_____ Tooth brushing Comments: _____ Bathing _____ Hair brushing or combing _____ Face washing _____ Haircuts _____ Nail trimming _____ Blowing nose
Does your child have difficulty completing grooming activities in a coordinated manner or with adequate skill? Mark all that apply.	_____ Tooth brushing Comments: _____ Bathing _____ Hair brushing or combing _____ Face washing _____ Haircuts _____ Nail trimming _____ Blowing Nose
How much assistance does your child require to complete grooming activities? Please add any comments:	_____Parent/caregiver provides all grooming tasks _____Child assists with some portions of tasks _____Child does most of task, parent helps some with details _____Child does task independently with reminders/cues _____Child does task independently as part of routine
Does your child avoid or fear grooming devices? Mark all that apply.	_____ Electric toothbrush Comments: _____ Barber's clippers _____ Dentistry tools Others:
Does your child avoid or fear the sounds associated with grooming activities? Mark all that apply.	_____ Hair dryer _____ Bath water _____ Hand dryer _____ Toilet flushing
What routines do you follow that are helpful for getting your child to participate in grooming activities?	Specify:
What happens if this routine is disrupted?	Impact on the child: Impact on family members:

DRESSING	
How independent is your child with undressing skills?	____Independent; no difficulties ____Able to remove clothing with reminders/cues ____Requires some assistance to remove challenging clothing ____Requires assistance to remove all clothing
How independent is your child with dressing themselves?	____Child picks out own clothes and puts them on with correct orientation ____Child requires cues/reminders to don clothing, can do by themselves after this reminder. ____Parent picks out clothes, child dons them independently, may or may not be backwards/twisted on body. ____Parent assists with orientation and donning clothing ____Child assists parent as parent dresses child ____Child requires complete assistance, doesn't help.
What routines do you follow that are helpful for getting your child to participate with dressing/undressing?	Specify:
What happens if this routine is disrupted? What happens if this routine is disrupted?	Impact on the child: Impact on family members:

TOILET TRAINING		
Is your child currently toilet trained for bladder?	YES / NO	At what age?
Is your child currently toilet trained for bowel?	YES / NO	At what age?
Does your child experience urinary/bowel issues?	Incontinence during the day YES / NO	Frequency:
	Bedwetting YES / NO	Frequency:
	Constipation YES / NO	Frequency:
	Loose stools YES / NO	Frequency:
	Lack of awareness YES / NO	Frequency:
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?	Specify:	
What happens if this routine is disrupted?	Impact on child: Impact on family members:	

SOCIAL FUNCTIONS/FAMILY LIVING	
Are you limited in attending family/social gatherings because of your child's behavior/reactivity to events?	YES / NO Comment:
Is your child able to attend birthday parties?	YES / NO Comment:
Are you able to leave your child alone with familiar, but not routine, caregivers for childcare?	YES / NO Comment:
Is your family able to maintain relationships with other families?	YES / NO Comment:
Is your family able to pursue hobbies and interests?	YES / NO Comment:
Is your child able to tolerate social touch or hugs from others?	YES / NO Comment:
Does your child have difficulty with different people's voices? Mark all that apply.	YES / NO If yes, which voices cause an issue: _____ Loud voices _____ Men's voices _____ Women's voices _____ Children's voices _____ Screaming _____ Crying Other:
What routines do you follow that are helpful for getting your child to participate in social situations?	Specify:
What happens if this routine is disrupted?	Impact on child: Impact on family members:

COMMUNITY SKILLS	
Is your child able to eat out at restaurants?	YES / NO Comments:
Is your child uncomfortable on elevators, escalators, or in cars?	YES / NO Comments:
Does your child have difficulty traveling on a variety of public transportation?	YES / NO Comments:

Does your child have difficulty flying on airplanes?	YES / NO Comments:
Is your child able to attend sleepovers?	YES / NO Comments:
Does your child have difficulty with loud, crowded sporting or similar events (enclosed or open stadium)?	YES / NO Comments:
Does your child have difficulty in the grocery store?	YES / NO Comments:
Does your child have difficulty in shopping malls or department stores?	YES / NO Comments:
Does your child have difficulty with long car rides?	YES / NO Comments:
Does your child have difficulty standing in lines (for their age)?	YES / NO Comments:

SOCIAL INTERACTION	
Does your child easily escalate from a whimper to an intense cry?	YES / NO Comments:
If your child uses atypical repetitive behavior, which behaviors are demonstrated? Mark all that apply.	_____ Hand flapping _____ Rocking _____ Head banging _____ Jumping _____ Smelling _____ Breath holding _____ Humming _____ Self-talk _____ Biting _____ Mouthing objects _____ Visual fixing _____ Spinning _____ Teeth grinding _____ Others:
Does your child struggle when there is excessive auditory input in his/her environment?	YES / NO How does your child react?
What transitions are difficult? (Transitions involve shifting between activities or environments)	Comments:
How long does it take to transition on average?	Comments:

What strategies are used to help ease transitions?	Comments:
Does difficulty with transitions cause distress to family members?	YES / NO Comments:
Does your child struggle to communicate their own needs?	YES / NO Describe:
What is your child's primary form of communication?	____ Talking ____ Singing ____ Sounds/Vocalizations ____ Pointing/Gesturing ____ Crying/Screaming
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 from a parent or caregiver?	
How does your child react in new/unfamiliar situations?	Specify:
Does your child have difficulty paying attention in noisy environments?	YES / NO Comments:
Does your child regularly avoid initiation of social interaction?	YES / NO How often? With whom?
Does your child avoid maintaining social interaction?	YES / NO How often? With whom?
Does your child experience difficulties with language expression? Mark all that apply.	YES / NO ____ Easily frustrated, anxious, or overwhelmed ____ Frequently mispronounces words (ex: 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 supporting your child's social skills?	Specify:
What happens if this routine is disrupted?	

<table>
<tr><th>PLAY SKILLS/PEER INTERACTION</th><th colspan="2"></th></tr>
<tr><td>How long is your child able to play alone?</td><td>_____ 1-2 minutes
_____ 3-5 minutes
_____ 5-10 minutes</td><td>_____ 10-30 minutes
_____ 30+ minutes</td></tr>
<tr><td>What are your child's preferred play activities?</td><td colspan="2">Specify:</td></tr>
<tr><td>How much time is spent daily in each of these activities?</td><td colspan="2">Passive activities (TV, Computer, etc):

Movement activities (Playground, Roughhouse play, etc):

Learning/Interactive play:</td></tr>
<tr><td>Is your child destructive towards toys?

Purposefully or accidentally rough with toys?</td><td colspan="2">YES / NO Comments:

YES / NO</td></tr>
<tr><td>Does your child enjoy playing alone (excluding TV watching or other screen time)?</td><td colspan="2">YES / NO Comments:</td></tr>
<tr><td>Does your child do well when playing with other children?
Mark the areas where your child has mastered:</td><td colspan="2">YES / NO

_____ Parallel play (Playing alongside other children)
_____ Interactive play-playing with other children
_____ Structure group play
_____ Making friends
_____ Pretend play
_____Maintaining friendships</td></tr>
<tr><td>Is your child preoccupied with seeking intense movement during play?
Mark all that apply.</td><td colspan="2">YES / NO Others:
_____ Spinning
_____ Bouncing
_____ Crashing
_____ Jumping
_____ Rocking</td></tr>
<tr><td>Does your child struggle to play in familiar settings?</td><td colspan="2">YES / NO Comments:</td></tr>
<tr><td>Does your child struggle to play in unfamiliar settings?</td><td colspan="2">YES / NO Comments:</td></tr>
<tr><td>Which playground equipment does your child play on?
Mark all that apply.</td><td>_____ None
_____ Swings
_____ Monkey bars
_____ Crawl tunnels
_____ Vertical climbers
_____ Merry-go-round</td><td>_____ Slide
_____ Climbing wall
_____ Bridges
_____ Teeter totter
_____ Spring riders
_____Ladders</td></tr>
</table>

<table>
<tr><td>Which playground equipment does your child avoid?</td><td>____ None
____ Swings
____ Monkey bars
____ Crawl tunnels
____ Vertical climbers
____ Merry-go-round
____ Ladders</td><td>____ Slide
____ Climbing wall
____ Bridges
____ Teeter totter
____ Spring riders
Other:</td></tr>
<tr><td>Does your child avoid certain types of toys?
(ex: textured toys)?</td><td colspan="2">YES / NO</td></tr>
<tr><td>Does your child exhibit poor safety awareness or engage in activities that are potentially dangerous (ex: jumping without regard)?</td><td colspan="2">YES / NO</td></tr>
<tr><td>Which surfaces does your child easily navigate while barefooted?
Mark all that apply.</td><td>____ Ascending stairs
____ Descending stairs
____ Grass
____ Gravel driveways
____ Woodchips
____ Sand</td><td>Comments:</td></tr>
</table>

SCHOOL SKILLS	
Where does your child attend preschool or school?	____ Homeschool ____ Daycare ____ Special needs preschool class ____ Regular education class ____ Special education class Other:
Does your child frequently change his/her grasp on pencils/other tools?	YES / NO
Which writing skills does your child struggle with/avoid? Mark all that apply.	____ Drawing/coloring ____ Tracing ____ Copying ____ Handwriting ____ Uses too much graded pressure ____ Uses too little grade pressure ____ Stabilization of paper while drawing/writing ____ Poor desk posture
Which skills seem to be more challenging than expected for your child? Mark all that apply.	____ Finding items within ‘hidden pictures’ ____ Phonetic learning ____ Telling time ____ Sequencing months of the year ____ Puzzles or construction/manipulation of materials ____ Spelling ____ Responding promptly to verbal instruction ____ Writing numbers and letters correctly Other:

Do you feel your child's drawings are immature for their 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? Mark all that apply.	_____ Closing/covering one eye while doing near work _____ Eye strain after reading a short period of time _____ Copying from chalkboard to paper _____ Short attention span in reading/copying _____ Turning head when reading across a page _____ Losing place often during reading _____ Needing finger or marker to keep place while reading _____ Reading comprehension _____ Reverses letters or words _____ Rereads or skips words _____ Doesn't look when manipulating objects _____ Tracking a moving object with head movement

Thank you for taking the time to complete this questionnaire. Please share any additional information that you feel is important to note here: