Private Occupational Therapy

In-Home Pediatric Occupational Therapy

Teacher Questionnaire

Please circle “yes” or “no” for each of the following questions.

Compared to his/her peers, is this child ADEQUATE in:
1. Ability to tolerate light and/or unexpected touch? YES NO
Comments:

2. Willing participation in messy activities (sand, playdough, fingerpaints, etc.)? YES NO
Comments:

3. Ability to sit upright in a chair without slouching or sprawling over the table? YES NO
Comments:

4. Ability to enjoy or participate in intense movement experiences such as swinging, high bouncing vigorously, or spinning around? YES NO
Does s/he avoid such experiences? YES NO
Does s/he crave such experiences, possibly not getting dizzy? YES NO
Comments:

5. Ability to get outer clothing on and off? YES NO
Comments:

6. Ability to move body in smooth, coordinated manner, i.e., not moving in an awkward or unusual way? YES NO
Comments:

7. Use of both hands together when necessary, e.g., catching a ball, beating rhythm sticks, or holding a cup while pouring juice? YES NO
Comments:

8. Consistent preference for using one hand when working with markers, crayons, or pencils? (age 4+) Left Right YES NO
Comments:

9. *Ability to work with a marker, crayon, or pencil? YES NO
Comments:

10. *Ability to work with scissors? YES NO
Comments

11. Ability to maintain sufficient attention span for things s/he enjoys? YES NO
Comments:

12. Ability to remain calm during routine classroom activities without becoming restless or fidgety? YES NO

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Comments:

13. Ability to eat and chew normally, without noticeable difficulties such as being excessively messy, refusing certain textures, or cramming food in mouth? YES NO
Comments:
In comparing this child with his/her peers, do you see PROBLEMS such as:

1. Overflow of movement in body parts not directly involved in an activity, e.g., *tongue protrusion, jaw motion, movements in nondominant hand, etc.? YES NO
*(Note: Tongue and jaw movements are normal in young children who are just learning a skill, such as using scissors or writing their name.)
Comments:

2. Over-sensitivity to noises, e.g., putting hands over ears, or complaining about sounds, when others are not bothered? YES NO
Comments:

3. Vision stress, e.g., inattentiveness when drawing or doing puzzles; insistence on“sameness” in day-to-day activities; lack of good, consistent eye contact; excessive shyness; unusual awkwardness? YES NO

4. Auditory language difficulties, e.g., when following directions, looks to others for cues before responding; has difficulty changing or rephrasing verbalizations when s/he is not understood; gives short or very limited verbal responses; cannot recall names of people or objects? YES NO
Comments:

5. Other behaviors that you feel may be atypical for his/her stage of development (drooling, stuttering, unusual postures or movements, etc.)? YES NO
Comments: