Physical and Academic Learning Services, PLLC

P.A.L.S.

1370 Frelsburg Rd, Alletyon TX 78935
Phone: 979-733-4870, Fax: 979-732-6465
palsotclinic@yahoo.com

Pre-Evaluation Questionnaire

Name of person evaluated:____DOB:________________________________

Education:

School and Grade (current or highest level achieved):____

Any Academic Problems in School?: ____

Any Special Classes or Modifications (ie: IEP or 504)?:____

Physical/Medical Issues:

History of Ear Problems? Y/N

Tubes? Y/N

Ear Infections? Y/N

Antibiotic use: Y/N

Allergies or food sensitivities? Y/N Details:____

History to adverse reactions to immunizations/Medications? Y/N_Details:____

____

History of seizures? Y/N Details:____

Difficulty with balance or coordination? Y/N

Difficulty with fine or gross motor skills (handwriting, sports, etc.)? Y/N

Pain threshold (please circle): High Normal Low

Temperature awareness? Y/N

Developmental Issues:

Difficulty or problems with birth/pregnancy? Y/N Details:____

Please circle milestones:

Crawled:	Early	Normal	Delayed
Walking:	Early	Normal	Delayed
Talking:	Early	Normal	Delayed
Toilet Training	Early	Normal	Delayed

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Speech/Language and Hearing Issues:

Hearing impairment or loss? Y/N Details:____

Sensitive to loud sounds? Y/N

Hypersensitivity to quiet sounds (ie: hearing sound others don't or before other hear them): Y/N

Sensitivity to sounds varied or makes a difference? Y/N

Difficulty with comprehension? Y/N

Difficulty with sound discrimination? Y/N Especially in a noisy environments? Y/N

Difficulty concentrating? Y/N Especially in a noisy environments? Y/N

Has difficulty following directions or multi-step instructions? Y/N

Delayed in slow response time? Y/N

Psychological/Emotional or Neurological Issues (current or past):

Easily angered, irritable, or impatient? Y/N

Anxiety/fears/phobias? Y/N

Attention Deficit Disorder diagnosis? Y/N

Bipolar disorder Diagnosis? Y/N

Social Issues:

Difficulty making or maintaining friends? Y/N

Inappropriate or immature social skills? Y/N

Discomfort or difficulty in social situations? Y/N

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Medications:

Please list all medications your child takes on a daily bases; including vitamins and over the counter supplements. Please indicate the "reason or "symptom" the medication is to treat.

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

Any additional space required for medication please provide on back of form.

Any prior therapy? Y/N Therapy provided in school? Y/N

Please provide any additional important information, comments, or concerns you feel is important for us to know: ____

____
____
____
____
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____
____
____
____

Date:______________________________Signature:____

Vickie Maertz, OTR,OTD
Pediatric Occupational Therapist
Owner