The Therapy Institute

The Therapy Institute provides a broad range of pediatric occupational therapy evaluation, treatment and consultation services for infants and children in a warm supportive environment. Our state-of-the-art facility includes multiple sensorimotor gyms, gross motor and fine motor treatment rooms and a full complement of suspension equipment.

Our director, Dr. Frederick B. Covington is an award winning inventor, mobile device medical app creator, host of the highest rated Occupational Therapy show, "Ask the OT", and an award winning author. Dr. Covington has been recognized for his pediatric treatment methods for individuals presenting with intellectual impairments, behavioral problems, ADHD, OCD, sensory integration deficits, learning disabilities, executive functional disorders, and several other diagnosis.

The Therapy Institute's occupational therapists evaluate and treat children from birth through teens with sensory integration deficits, behavioral challenges, developmental delays, gross and fine motor delays, difficulty focusing and attending, perceptual impairments, illegible handwriting and dyspraxia. Diagnoses treated include Sensory Processing Disorder, dyspraxia, dysgraphia, gross motor and fine motor incoordination, Developmental Coordination Disorder, hypotonia, attention deficits, autistic spectrum disorders including PDD and Aspberger's syndrome, neurological impairments, Down syndrome, cerebral palsy and others.

We offer school and camp consultations and will collaborate with any and all of the professionals on your child's team. Sensory diets and home programs are prepared and upgraded to supplement occupational therapy treatment and meet your child's individual needs as needed. We provide workshops for parents and teachers both at our offices, at professional conferences, and in schools.

The Therapy Institute
Dr. Frederick B. Covington, OTD. Director
"Treating the child, not the diagnosis."
Tel: 888-991-2368 Fax: 888-991-2368 Email: AskDrCovington@gmail.com

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PATIENT INFORMATION

1. Child's name:_____ Today's date:_____

   Birthdate:_____ Age:_____ Sex:_____ Adopted?_____

   Parent completing this questionnaire:_____

2. Current School:_____ Grade:_____

   Teacher(s):_____

   Prior Schools:_____ Grades repeated?_____

   Has he/she been in a special classroom, attended remedial or enrichment classes? _____

   Please describe:_____

   _____

3. Mother's name:_____

   Address: _____

   Home phone:_____ Cell phone:_____ Work phone:_____

   Fax:_____ Occupation:_____ E-mail address:_____

   Father's name:_____

   Address: _____

   Home phone:_____ Cell phone:_____ Work phone:_____

   Fax:_____ Occupation:_____ E-mail address:_____

4. Child's physician:_____ Phone number:_____

Address:_____

How long has your child been under this physician's care?_____

5. Has your child been diagnosed as having any medical or educational condition?_____

   If so, what?_____

   Who made the diagnosis and when was it made?_____

6. Referred by:_____ Relationship to child:_____

7. What are your concerns about your child ? (Please provide a detailed explanation)

   _____

   _____

   _____

   _____

8. What are the school's primary concerns? _____

   _____

   _____

   _____

   _____

9. Is there any discrepancy in your impression of your child versus the school's?

   _____

   _____

   _____

   _____

10. Did either parent or any relative experience the same difficulties as your child? Explain:

    _____

    _____

    _____

    _____

11. Has your family experienced any recent crisis or stress that you feel is important to your child's

development at this time? _____

_____

_____

12. What do you hope to gain from this evaluation? _____

_____

_____

_____

_____

13. What are your concerns about your child ? (Please provide a detailed explanation)

_____

_____

_____

_____

14. What are the school's primary concerns? _____

_____

_____

_____

_____

15. Is there any discrepancy in your impression of your child versus the school's?

_____

_____

_____

_____

16. Did either parent or any relative experience the same difficulties as your child? Explain:

_____

_____

_____

_____

17. Has your family experienced any recent crisis or stress that you feel is important to your child's development at this time? _____

_____

_____

18. Has your child seen, or is currently seeing any other specialists for an evaluation or treatment? If so, whom?

_____

MEDICAL HISTORY

1. Birth weight: _____ lbs. _____ oz. Apgars:_____,_____
2. Pregnancy: Full term: _____ Premature: _____
3. Mother's health during pregnancy: _____
4. Problems encountered during pregnancy (illness, injury, stress, anemia, medications, etc):

   _____
5. Labor: Total length of labor: _____ Induced birth? _____ Breech presentation? _____
6. Delivery: Vaginal: _____ Cesarean:_____ Forceps:_____ Anesthesia: _____
7. Problems encountered during labor and delivery: _____

   _____
8. Neonatal history: *(Check all that apply)*

   jaundice: ____ cyanosis: ____ limpness: ____ stiffness: ____congenital defects: _____

   oxygen: _____ transfusions: _____ tube feedings:_____ immobilization: _____
9. Were there any feeding difficulties in the first month? _____

   _____
10. Were any other problems encountered in the first month? _____

    _____
11. List illnesses, injuries, or surgeries the child has had and age at the time of illness:

    _____

    _____
12. Has child had high fevers? _____ seizures: _____frequency: _____
13. General health at present: good: _____ fair: _____ poor: _____ Describe: _____
14. List any present medications: _____
15. Ear infections: yes: _____ no: _____ frequency: _____ Tubes: yes:____no: _____When:_____
16. Allergies: yes: ____ no:____ type:_____
17. Any medical precautions? _____
18. Names and ages of child's siblings:

    _____

    _____

DEVELOPMENTAL HISTORY

Check all that describe your child as an **infant:**

Fussy, irritable		Good, non-demanding	
Quiet		Passive	
Active		Liked being held	
Resisted being held		Floppy	
Tensed muscles when being held		Slept well	
Irregular sleep patterns		Overly active, never still unless sleeping	

Comments:

_____

_____

_____

_____

Check all that describe your child most at **present:**

Has positive self esteem		Usually happy	
Mostly quiet		Overly active	
Tires easily		Talks constantly	
Restless		Stubborn	
Difficulty separating from primary caretakers		Difficulty shifting from one activity to another	
Over reacts		Fights frequently	
Frequent temper tantrums		Clumsy	
Resists change		Nervous habits or tics	
Falls often		Poor attention span	
Easily frustrated		Distractible	
Cries often		Rocks self frequently	
Has difficulty learning new tasks			

Comments:

_____

_____

_____

_____

Approximate age at which your child did the following:

Raised head		Pulled to standing	
Crawled on hands and knees		Stood alone	
Sat alone		Walked	

Your general impression of your child's motor development:

	Advanced	Normal	Slow
Gross motor: (running, jumping, ball play)			
Fine motor: (beading, lacing, cutting with			
scissors) Handwriting/coloring skills:			

Comments:

_____

_____

_____

_____

DAILY SCHEDULE

1. My child is in school/day care from: _____ to _____.
2. Please describe your child's morning routine (typical school day). _____

   _____

   _____
3. What factors most interfere with a smooth morning? _____

   _____

   _____
4. Provide an overview of your child's usual after-school routine.

   _____

   _____
5. What are the biggest deterrents to a smooth evening?

   _____

   _____
6. What prevents or facilitates smooth homework sessions? How involved are you in the process?

   _____

   _____
7. How does your child choose to spend his/her free time at home?

   _____
8. Does your child play appropriately with toys? If not, explain:

   _____
9. Please describe your child's bedtime routine. What tends to relax or over-stimulate him/her in the evening? How long does it take your child once put to bed, fall asleep?

   _____

   _____
10. How does you child cope with weekends (e.g., more physically active, stays in front of the TV, play date with friends, type of demeanor compared to week days)?

    _____

    _____
11. What is his/her mood like when he/she returns to school after the weekend?

    _____

BEHAVIOR & SOCIAL SKILLS

1. Who is primarily responsible for discipline and rule setting at home? _____
2. What methods are most effective? How does your child respond to discipline?

   _____

   _____
3. Does your child tantrum? _____ How often? _____
4. Have you observed any head banging or self-destructive behavior? _____

   _____
5. How does your child respond to authority figures outside of the home?

   _____

   _____
6. How does your child respond to structure? Please elaborate: _____

   _____

   _____

   _____
7. Does your child have a "best friend"? _____ Older or younger? _____
8. Is your child attuned to social cues? Is he/she socially appropriate (at school, home, play date, party)? _____

   _____

   _____
9. How does your child do with one-on-one play dates? Does he/she request them?

   _____

   _____

   _____
10. Are you concerned with your child's ability to function at birthday parties, other group or crowded situations? (e.g. guests at home, visiting friends or relatives, youth group, synagogue, church, mall, movie theater, etc.) _____

    _____

    _____

    _____

SELF-CARE SKILLS

EATING SKILLS:

Feeds his/herself: all: ____ most: ____ some: ____

Uses: fingers: ____ spoon: ____ fork: ____ knife: ____ cup: ____ Level of proficiency: _____

Is your child a messy eater? _____ Please explain: _____

_____

Does your child object to certain foods, tastes, and textures? yes:____ no:____

Please explain: _____

DRESSING:

	Remove	Put on		Remove	Put on
Undershirt			Socks		
Shirt			Shoelaces		
Underpants			Shoes		
Pants			Buttons		
Snaps			Velcro closures		
Zippers			Belt		

COMMENTS:_____

_____

BATHING:

Does your child take a bath? _____ Shower? _____ Does he/she enjoy it?_____

Is he/she sensitive to the temperature of the water? _____

How much assistance does your child need to wash his/her body? _____

Face: _____ Hair: _____ Dry off: _____

TOILET TRAINING:

Age trained for days: _____ Age trained for nights: _____

Issues associated with toilet training: _____

_____

Are there any other concerns about your child's dependence, independence or resistance to self-care tasks at home or in school: _____

_____

_____