Web: therayouth.org Email: elizabeth@therayouth.org Phone: 908-662-1000

Teacher Questionnaire

Please take a moment to fill out our intake form before your visit. All information is kept completely confidential.

Patient First Name – *Required*

Patient Last Name – *Required*

Please provide at least one phone number. Your mobile number can be used to look up your Account and receive text message appointment reminders.

Mobile Phone

A mobile phone is required if you would like to receive SMS appointment reminders.

Home Phone

Street Address

City

State

Postal / Zip

Date of Birth

Gender

Sex

TEACHER QUESTIONNAIRE

Dear Teacher,
We are looking forward to evaluating this student for OT services. Your answers on this questionnaire will help us understand this student's ability to function in the classroom. Please list your concerns, if any, and provide all information you feel may be relevant. This student and/or student's parents are being asked to fill out similar questionnaires. Thank you very much for your time and concern.

Please provide the following: *– Required*

Student Name:

School Name:

School Phone:

SchoolAddress:

What are your concerns and questions about this student's learning, development, and/or behavior? – *Required*

Please describe this student's strengths and weaknesses in the classroom. – *Required*

Do you have any other concerns about personality, emotional, or behavioral functioning? – *Required*

Please rate the following SKILLS with notes where applicable

General level of activity – *Required*

- [ ] Weakness Compared to Peers
- [ ] Average
- [ ] Strength Compared to Peers

Emotional regulation – *Required*

- [ ] Weakness Compared to Peers
- [ ] Average
- [ ] Strength Compared to Peers

Flexibility / acceptance of change – *Required*

- [ ] Weakness Compared to Peers

- [ ] Average

- [ ] Strength Compared to Peers

Following directions – *Required*

- [ ] Weakness Compared to Peers

- [ ] Average

- [ ] Strength Compared to Peers

Paying attention – *Required*

- [ ] Weakness Compared to Peers

- [ ] Average

- [ ] Strength Compared to Peers

Initiating / sequencing / finishing tasks – *Required*

- [ ] Weakness Compared to Peers

- [ ] Average

- [ ] Strength Compared to Peers

Organizing work and space – *Required*

- [ ] Weakness Compared to Peers

- [ ] Average

- [ ] Strength Compared to Peers

Consistency of performance – *Required*

- [ ] Weakness Compared to Peers

- [ ] Average

- [ ] Strength Compared to Peers

Interactions with peers – *Required*

- [ ] Weakness Compared to Peers

- [ ] Average

- [ ] Strength Compared to Peers

Interactions with adults – *Required*

- [ ] Weakness Compared to Peers

- [ ] Average

- [ ] Strength Compared to Peers

Following directions – *Required*

- [ ] Weakness Compared to Peers
- [ ] Average
- [ ] Strength Compared to Peers

Gross motor skills – *Required*

- [ ] Weakness Compared to Peers
- [ ] Average
- [ ] Strength Compared to Peers

Fine motor skills – *Required*

- [ ] Weakness Compared to Peers
- [ ] Average
- [ ] Strength Compared to Peers

Writing: legibility – *Required*

- [ ] Weakness Compared to Peers
- [ ] Average

- [ ] Strength Compared to Peers

Writing: speed and effort – *Required*

- [ ] Weakness Compared to Peers
- [ ] Average
- [ ] Strength Compared to Peers

Dressing skills (if applicable) – *Required*

- [ ] Weakness Compared to Peers
- [ ] Average
- [ ] Strength Compared to Peers
- [ ] N/A

Hygiene skills (if applicable) – *Required*

- [ ] Weakness Compared to Peers
- [ ] Average
- [ ] Strength Compared to Peers
- [ ] N/A

Feeding skills (if applicable) – *Required*

- [ ] Weakness Compared to Peers

- [ ] Average

- [ ] Strength Compared to Peers

- [ ] N/A

Managing supplies, cleaning up and participating in other community maintenance tasks – *Required*

- [ ] Weakness Compared to Peers

- [ ] Average

- [ ] Strength Compared to Peers

Consents — Step 3 of 3

You are completing the following intake forms: Teacher Questionnaire

Teacher Questionnaire — Consents

Accuracy of Information

☐ I certify that the above medical information is correct to my knowledge. – *Required*

Privacy and Sharing of Information

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

☐ I agree – *Required*

Cancellation policy

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the therapists' day that could have been filled by another client. As such, we require a twenty four hour notice for any cancellations or changes to your appointment. Clients who provide less than twenty four hour notice, or miss their appointment, will be charged a cancellation fee to the card on file.

☐ I am aware of the Cancellation Policy. – *Required*