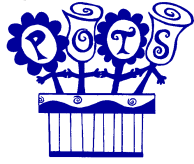


Pediatric Occupational Therapy Services, LLC



About Us

Pediatric Occupational Therapy Services (POTS) 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 compliment of suspension equipment.

Our director, Dr. Chaye Lamm Warburg, OTR is a SIPT certified, MEDEK trained, Board of Education certified, pediatric occupational therapist with 33 years of experience, who founded P.O.T.S. 19 years ago. We have a staff of 12 full-time and part-time therapists with a broad range of experience and clinical skills.

Services Provided

POTS 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 Asperger's syndrome, neurological impairments, Down syndrome, cerebral palsy and others.

Cutting edge treatment techniques include, but are not limited to: sensory integration, Handwriting Without Tears, Therapeutic Listening, The Listening Program, MEDEK™, Interactive Metronome®, Core Activation, the Alert Program and Brain Gym®.

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. We provide workshops for parents and teachers both at POTS, at professional conferences, and in schools.

For More Information, Contact Us At:

Pediatric Occupational Therapy Services, LLC

Dr. Chaye Lamm Warburg, OTR/L. Director

Committed to empowering each child to maximize his/her potential

1415 Queen Anne Road. Teaneck, NJ 07666

Tel: 201-837-9993 Fax: 201-837-9465 Email: Potsoffice@aol.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. Which of the following specialists has your child seen, or is currently seeing for an evaluation or treatment ?

Specialist (Doctor's name)	Date(s) seen	Phone number	Findings
Pediatric Neurologist			
Developmental Pediatrician			
Learning Specialist			
Psychologist			
Psychiatrist			
Speech Pathologist			
Audiologist			
Physical Therapist			
Occupational Therapist			
Developmental Optometrist			
Ophthalmologist			
Nutritionist			
Child Study Team			

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 of child's siblings: Age Sex Grade School

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 your 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: _____