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PARENT/CARER QUESTIONNAIRE/ INTAKE FORM:

This questionnaire has been developed to get a better understanding of your child. Please answer as many of the questions as possible.

Date Form Completed:			
Name:	Surname	First name	Middle name/s
Date of Birth:	DD/MM/YYYY		
Address:			
Email Address:			
Phone Numbers:			
School:			
Grade:			

REASON FOR REFERRAL

Referred By?	
Reason for Referral?	
Does your child have a medical diagnosis?(if yes, please list)	
What are your child's strengths (please list minimum of 3)	
What are your child's difficulties?	

ADDITIONAL SERVICES INVOLVED:

What other professionals (if any) has your child been involved with?
Please give brief details of your goals, when your child was seen by this professional and their contact details:

Therapist	*Year Seen:*	*Goals/outcome of therapy, treatment or assessment:*	*Contact details:*
Speech Therapist:			
Psychologist:			
Paediatrician:			
Occupational Therapist:			
Dietician:			
Gastroenterologist:			
Optometrist:			
Tutor:			
Other:			
Other:			

**If you child has seen another professional please provide copies of their report/s.*

FAMILY DETAILS

Please give details regarding the following:

Parent 1:	**Parent 2:**
Full Name:	Full Name:
Preferred hand:	Preferred hand:
Sibling 1:	**Sibling 2:**
Name:	Name:
Preferred hand:	Preferred hand:
Any areas of concern?	Any areas of concern?
Sibling 3:	**Sibling 4:**
Name:	Name:
Preferred hand:	Preferred hand:
Any areas of concern?	Any areas of concern?
Is there any family history of ADHD, ASD, learning or coordination problems?	

MEDICAL HISTORY

Please give details regarding the following:

Past Health (including significant injuries or illnesses):	
Present Health:	
Sleep: (Getting to sleep, staying asleep, appropriate length	
Diet:	
Does your child take any medications regularly?(if yes, provide name and purpose of medication)	

Has the following been tested? (please ensure you fill out this section)

	Tested?	When	Organisation	Results
Vision	Yes/No			
Hearing	Yes/No			

PREGNANCY + BIRTH HISTORY

Were there any complications during birth and/or pregnancy?	
Full term/number of weeks?	
Type of delivery?	
Childs health condition after birth?	

DEVELOPMENTAL MILESTONES

At what age (approximately) did your child:

Roll:		
Sit:		
Crawl:		
Walk:		
Toilet train:	Day:	Night:
Speak first words:		
Speak in sentences:		

SCHOOL

Does your child have friends or are they having difficulties with friendships?	
Does your child enjoy school + what do they enjoy about it?	
What subjects do they find easy?	
What subjects do they find difficult?	

<u>SKILLS AND THEIR UNDERLYING ABILITIES</u>

Please tick the appropriate box in the following areas in relation to your child's performance in these areas:

Motor Skills	**Very Good**	**Good**	**Average**	**Poor**	**Very Poor**	**Comments**
Catching a ball						
Throwing a ball						
Kicking a ball						
Jumping						
Balancing						
Hopping						
Climbing						
Riding a bicycle						
Swimming						
Underlying Abilities	**Very Good**	**Good**	**Average**	**Poor**	**Very Poor**	**Comments**
Coordination						
Body Awareness – avoids bumping into objects and others						
Muscle tone/Postural control						
Energy levels at the end of the day						
Use of dominant hand (circle)	Right	Left	Unsure			
Ability to sit still						
Fine Motor + Visual Processing Skills	**Very Good**	**Good**	**Average**	**Poor**	**Very Poor**	**Comments**
Drawing						
Handwriting-formation, size, spaces						
Handwriting speed						
Cutting out						
Colouring in						
Pencil grip						
Finding place on page e.g reading						
Written Expression	**Very Good**	**Good**	**Average**	**Poor**	**Very Poor**	**Comments**
Capital letter use						

Use of punctuation						
Generating ideas for writing						
Organisation of ideas(eg sentence structure, within text type)						
Write age appropriate quantity in given timeframe						
Attention, Concentration + Executive Functioning	**Very Good**	**Good**	**Average**	**Poor**	**Very Poor**	**Comments**
Listening						
Sitting Still						
Task Perseverance						
Concentration						
Gets started + organised for task						
Impulse Control						
Remembering goal of a task						
Personal Care	**Very Good**	**Good**	**Average**	**Poor**	**Very Poor**	**Comments**
Dress/undress						
Toileting						
Puts on clothes w/ correct orientation						
Clothes fastenings eg zips, buttons						
Using a fork & knife						
Tidiness when eating						
Brushing teeth						
Showering self						
Managing period (period undies, pads, tampons etc) *NA if not relevent						
Language	**Very Good**	**Good**	**Average**	**Poor**	**Very Poor**	**Comments**
Remembering a message						
Follows 1 step instructions						
Follows complex instructions						
Social/Emotional skills	**Very Good**	**Good**	**Average**	**Poor**	**Very Poor**	**Comments**

Joining in games						
General behaviour						
Makes and keeps friends						
Coping w/ changes, new situations						
Eye contact						
Problem solving						
Separating from parents						
Understands basic emotions (happy, sad, angry)						
Understands complex emotions eg worried, embarrassed, annoyed						
Expresses emotions appropriately						

SENSORY

	Yes	Sometimes	No
Seems to be in constate state of movement			
Frequently bumps into things/appears clumsy			
Reacts strongly to being bumped or touched			
Avoids messy play and doesn't like to get hands dirty			
Prefer or seek out rough play			
Loses place when reading or copying from board			
Reacts negatively to loud noises			
Reacts strongly to smells			
Fussy eater, gags on food			
High pain threshold			

Please list your girls for your child's therapy. Please be as specific as possible:
1.
2.
3.
4.
5.

Thank you!

Bec

Rebecca Middeldorp- Occupational Therapist