***Clinic Name Company Logo***

Parent questionnaire:

Information about your child

The following details will be recorded and stored as part of a confidential occupational therapy file.

**PERSONAL INFORMATION**

Child’s Full Name: [[tb]] Preferred Name: [[tb]]

Address: [[tb]]

Date of Birth: [[tb]] Indigenous status: [[tb]]

School: [[tb]]

School Year Level: [[tb]]

Class Teacher/s: [[tb]] Email: [[tb]]

**PARENT/CARER INFORMATION**

Parent/Carer 1 name: [[tb]] Relationship to child: [[tb]]

Address (if different to above): [[tb]]

Indigenous status: [[tb]]

Phone: [[tb]] Mobile: [[tb]] Email: [[tb]]

Parent/Carer 2 name: [[tb]] Relationship to child: [[tb]]

Address (if different to above): [[tb]]

Indigenous status: [[tb]]

Phone: [[tb]] Mobile: [[tb]]Email: [[tb]]

Are shared care arrangements in place? (Please tick)

[[ta]]

If Yes, please provide details:

[[cb]] Yes [[cb]] No

**REFERRAL INFORMATION**

[[ta]]

Please indicate any specific concerns you have about your child’s participation at school, home or in the community. Identify any particular tasks he/she has more difficulty with than his/her same aged peers.

[[ta]]

What impact do these concerns have on your child’s life?

Is there anyone else in your family that has/had similar issues? [[cb]] Yes [[cb]] No

[[ta]]

**HEALTH**

Please provide details of GP if you would like copies of reports to go to him/her

GP Name:

GP Contact details:

Does your child have any significant health problems? [[cb]] Yes [[cb]] No

[[ta]]

Please comment:

Does your child have any allergies? [[cb]] Yes [[cb]] No

[[ta]]

Please comment:

Has your child had an assessment of hearing? [[cb]] Yes [[cb]] No

[[ta]]

If Yes, Please provide details:

Has your child had an assessment of eyesight? [[cb]] Yes [[cb]] No

[[ta]]

If Yes, Please provide details:

Is your child on any medication? [[cb]] Yes [[cb]] No

[[ta]]

Please specify with dosage:

Has your child had any contact in the past with or is currently seeing any of the following?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Service | **Yes/No** | **Who** | **When** | **Contact Details** |
| Paediatrician | [[ta]] | [[ta]] | [[ta]] | [[ta]] |
| Occupational Therapist | [[ta]] | [[ta]] | [[ta]] | [[ta]] |
| Physiotherapist | [[ta]] | [[ta]] | [[ta]] | [[ta]] |
| Psychologist | [[ta]] | [[ta]] | [[ta]] | [[ta]] |
| Speech Pathologist | [[ta]] | [[ta]] | [[ta]] | [[ta]] |
| Optometrist | [[ta]] | [[ta]] | [[ta]] | [[ta]] |
| Hearing specialist | [[ta]] | [[ta]] | [[ta]] | [[ta]] |
| Other | [[ta]] | [[ta]] | [[ta]] | [[ta]] |

**SOCIAL EMOTIONAL**

[[ta]]

Please describe your child’s personality (e.g. shy, happy, easily excited, angry)

Does your child have any favourite activities/toys/games/interests?

Have there been any recent disruptions in family life? [[cb]] Yes [[cb]] No

[[ta]]

Please comment:

|  |  |  |
| --- | --- | --- |
| **Does your child:** | **Yes/ No** | **Comments** |
| Play with others? | [[ta]] | [[ta]] |
| Withdraw? | [[ta]] | [[ta]] |
| Prefer a group? | [[ta]] | [[ta]] |
| Have friends at home/school? | [[ta]] | [[ta]] |
| Have trouble making friends? | [[ta]] | [[ta]] |

|  |
| --- |
| **Are any of these behaviours causing concern? (Please tick)** |
| Lack of eye contact | [[cb]] Yes [[cb]] No | Dislike of changes to routine | [[cb]] Yes [[cb]] No |
| Nervous habits | [[cb]] Yes [[cb]] No | Poor sleep habits | [[cb]] Yes [[cb]] No |
| Aggression | [[cb]] Yes [[cb]] No | Distractibility | [[cb]] Yes [[cb]] No |
| Excessive tantrums | [[cb]] Yes [[cb]] No | Becomes frustrated | [[cb]] Yes [[cb]] No |
| Obsession about a toy/object/topic | [[cb]] Yes [[cb]] No | Other (describe) | [[cb]] Yes [[cb]] No |

**EARLY DEVELOPMENT**

Please comment on mother’s pregnancy and your child’s birth:

[[ta]]

When did your child:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Early** | **Usual Time** | **Late** | **Not sure** | **Usual Age** |
| **Smile** | [[ta]] | [[ta]] | [[ta]] | [[ta]] | 6 weeks |
| **Roll** | [[ta]] | [[ta]] | [[ta]] | [[ta]] | 4-6 months |
| **Sit** | [[ta]] | [[ta]] | [[ta]] | [[ta]] | 6-7 months |
| **Crawl** | [[ta]] | [[ta]] | [[ta]] | [[ta]] | 7-9 months |
| **Walk** | [[ta]] | [[ta]] | [[ta]] | [[ta]] | 12-15 months |
| **Talk (words)** | [[ta]] | [[ta]] | [[ta]] | [[ta]] | 12-18 months |
| **Talk (sentences)** | [[ta]] | [[ta]] | [[ta]] | [[ta]] | 18-24 months |

Please comment on any previous or current issues with:

|  |  |  |
| --- | --- | --- |
|  | **Please tick** | **Please comment** |
| Feeding (breast/bottle) | [[cb]] Yes [[cb]] No | [[ta]] |
| Eating/drinking | [[cb]] Yes [[cb]] No | [[ta]] |
| Sleeping | [[cb]] Yes [[cb]] No | [[ta]] |
| Toilet training | [[cb]] Yes [[cb]] No | [[ta]] |
| Dressing | [[cb]] Yes [[cb]] No | [[ta]] |

Any other information that we should know?

[[ta]]

**Thank you for completing this form.**

**Completed by: [[tb]] Relationship to child:** [[tb]]

**Date: [[tb]]**