Occupational Therapy For Children
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Parent Questionnaire

Date Completed:	
Child's Name:	Date of Birth:
Place in Family (names and ages of siblings):	
Childcare / Kindy / School (circle and name):	
Carer:	Year Level:

The information provided in this questionnaire is important in determining the most appropriate assessment and intervention for your child. Your careful consideration is appreciated and expected. If you are unsure please indicate in the space provided or by stating.

Thank you for your assistance.

MEDICAL INFORMATION

Medical Diagnosis (tick)

Autism Spectrum Disorder	❒	Asperger's Syndrome	❒
PDD – NOS	❒	Other	❒

Is your child (tick)

Registered with Autism SA	❒	Eligible to use the HCWA	❒
Under a FPS/Mental Health Plan	❒	Under the Medicare Autism Initiative	❒
Under an Enhanced Primary Care plan	❒	Other	❒

Medical history: (colic, allergies, eczema, ear infections, asthma, sinus, seizures)
Paediatrician currently involved:
Family GP involved:
Current medication :
Hearing: (concerns/tests/results)
Vision: (concerns/tests/results)

Previous / Ongoing Interventions (tick)

Speech Pathology	❒	Physiotherapy / hydro	❒	Biomedical	❒
Psychology / ABA	❒	RDI therapy	❒	D.I.R Floortime	❒
Gluten free diet	❒	Chelation Therapy	❒	Other	❒

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List what you see as your child's major areas of need pertinent to this assessment (tick)

Speech ❒	Sensory ❒	Social ❒
Behaviour ❒	Toileting ❒	Eating/ food ❒
Learning ❒	Gross Motor ❒	Fine motor ❒
Play ❒	Self Stimulation ❒	Communication ❒

Are there similarities with other members of the (extended) family?

PHYSICAL OR MOTOR DEVELOPMENT

Birth / Neonatal History (e.g. full term; unusual; quick birth; blueness, jaundice, illness, Apgar rating)

Milestones (age in months when)

Sat:	**Crawled correctly:**	**Walked:**
Spoke first words:	**Sentences:**	

The rating scale is graded in response to a child's skill, ability or behaviour in the following areas. Ratings should be based on observations made at home and during play activities. If unsure or not observed, please indicate in the box provided.

PLAY (predominantly but not exclusively gross motor)	**Never**	**Sometimes**	**Usually**	**Always**	**Not ob./ Unsure**
Appears coordinated for age					
Enjoys outside play					
Uses a dominant L or R hand (please circle)					
Plays with balls – throws, kicks/catches/hits (circle)					
Pushes/pulls/pokes at things and people					
Seems weaker/stronger than others (circle)					
Physically tires quicker than others					

PLAY (predominantly but not exclusively fine motor)	**Never**	**Sometimes**	**Usually**	**Always**	**Not ob./ Unsure**
Enjoys indoor play					
Can create own play					
Plays with blocks, construction items					
Plays with cars, trains, dolls					
Plays with puzzles					
Plays with scissors, drawing, painting activities					

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Favourtie Indoor play?
Favourite Outdoor play?
What is your home outdoor play equipment?
Extracurricular / Community / Group activities? (e.g. Drama, Swimming, Dancing, Music)

MEALTIMES	**Never**	**Sometimes**	**Usually**	**Always**	**Not ob./ Unsure**
Uses – spoon or fork					
Knife with fork					
Fingers					
Stays seated at the table					
Fidgets					
Good appetite/eats all food groups					
Messy eater					
Food preferences determined by texture, taste, smell					
Reaction to different foods (e.g. 'hyper' behaviour)					

DRESSING	**Never**	**Sometimes**	**Usually**	**Always**	**Not ob./ Unsure**
Independent for age					
Organises and completes independently					
Manages orientation of clothing					
Can do up buttons					
Can put on socks					
Can put on shoes					
Can tie laces					
Can manage zips					
Needs prompts to keep on task					

WASHING / GROOMING	**Never**	**Sometimes**	**Usually**	**Always**	**Not ob./ Unsure**
Bath (participates well)					
Showers (participates well)					
Washing face (participates well)					
Washing hair (participates well)					
Hair brushing (participates well)					

SLEEP	**Never**	**Sometimes**	**Usually**	**Always**	**Not ob./ Unsure**
needs to get to bed early and needs a lot of sleep					
restless sleeper / awakens during the night (circle)					
bedwetting/soiling (circle)					
awakes well and is more energetic in the mornings					
is more alive and energetic later in the day					

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In bed at: pm	Awakens am	How long does it take to get to sleep?
Needs daytime sleep? Yes ❑ No ❑ (Tick)		

TOILET	Never	Sometimes	Usually	Always	Not ob./ Unsure
Bladder control - day					
Bladder control - night					
Bowel control - day					
Bowel control - night					
Dressing					
Pressing button					
Washing Hands					

SENSORY PREFERENCES

TOUCH (Tactile)	Never	Sometimes	Usually	Always	Not ob./ Unsure
Is tolerant of affectionate hugs from family					
Is tolerant of being touched or hugged by others					
Is tolerant of different textures in clothing (labels, seams)					
Is tolerant of having face / hair being washed					
Is tolerant of teeth / hair being brushed					
Is tolerant of different textures on hands (e.g. food, glue)					
Is tolerant of different textures of food in mouth					
Is tolerant of being bumped/jostled in groups					
Tends to chew or mouth objects					

MOVEMENT / BALANCE / HEIGHT	Never	Sometimes	Usually	Always	Not ob./ Unsure
Is physically adventurous					
Is tolerant of swings					
Is tolerant of spinning movements					
Is tolerant of slippery dips					
Is tolerant of heights (including stairs)					
Experiences motion sickness whilst in the car					
Is tolerant of unstable surfaces					
Is tolerant of climbing frames					

BODY / MUSCLE / AWARENESS / POSITION SENSE	Never	Sometimes	Usually	Always	Not ob./ Unsure
Needs a light on at/all night					
Resists having eyes or face covered					
Appears clumsy, accident prone,					
Spills/tips/knocks over things					
Heavy handed/footed					
Pushes/pulls/pokes at things and people					
Is tolerant of 'rough and tumble' play					
Is aware of own body space with others or structures.					
Physically tires quicker than others					

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VISION	**Never**	**Sometimes**	**Usually**	**Always**	**Not ob./ Unsure**
Is attracted to/excited by certain visual stimuli (e.g. lights)					
Sensitive to light					
Easily locates things					
Walks into/in the way of others/things					

HEARING	**Never**	**Sometimes**	**Usually**	**Always**	**Not ob./ Unsure**
Sensitive to some noises (shopping centre, crowds)					
Sometimes thought to have difficulty hearing					
Can follow more than two step instructions					
Seeks out some sounds					

SMELL	**Never**	**Sometimes**	**Usually**	**Always**	**Not ob./ Unsure**
Is particularly sensitive to smells					
Seeks out certain smells / sniffs things					

BEHAVIOUR (patterns / reactions current)	**Never**	**Sometimes**	**Usually**	**Always**	**Not ob./ Unsure**
Is easy going					
Copes with change					
Has good frustration tolerance					
Is able to organise self					
Needs to control play with others					
Is Aware and Attentive to others					
Creates own play					
Plays with family well					
Has good self confidence					

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CLIENT CONSENT

I, ________________________________ give consent to **Occupational Therapy For Children** to discuss relevant information regarding my child, ________________________________, with the following:

(please tick and add names where appropriate)

❐	Child Care/ Kindy/School	Ph No:
❐	Speech Pathologist	Ph No:
❐	Psychologist	Ph No:
❐	Paediatrician	Ph No:
❐	GP	Ph No:
❐	Other	Ph No:
	Other	Ph No:

I give consent to Occupational Therapy For Children to send written/electronic documentation to:

❐ Self	Postal
	Email
❐ Teacher	Email
❐ Other	Email
❐ Other	Email

TERMS & CONDITIONS: (please initial next to each condition to indicate you have read & understood the following)

1	I agree to **PAY IN FULL** all professional fees and sale items charged on the day of each service	
2	I understand **A CANCELLATION FEE of $50.00** will be charged in the event of a non arrival or appointment cancellation after 5pm for a next day's appointment.	
3	I agree to not bring my child to OTFC if they have a temperature, are unwell or are contagious.	
4	I agree **not to leave my child and or siblings unsupervised** while attending OTFC. If I need to leave while my child is in treatment, I will inform the therapist and I will return prior to the end of my child's appointment.	
5	If an account remains **unpaid for a period of 30 days**, OTFC reserves the right to pass the debt to a collection agency of their choice and if necessary, to take legal action to recover the debt. Debt Recovery cost, including any legal expenses will be included.	

Parent / Care's Name: ________________________________

Signed and Dated: ________________________________

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