1. General Information

Name of Child:

Date of Birth:

Name of person filling questionnaire:

Relationship to child:

Preferred contact number:

Home Address:

Email Address:

Date questionnaire completed:

Your impressions and opinions of your child's abilities and comparative difficulties are very important in a complete assessment of your child. Please complete this questionnaire adding additional comments as necessary. This information will be treated as confidential at all times.

2. Medical History

Birth Weight:

Pregnancy: (tick as appropriate)

Full Term

Premature
(Born at) ___ weeks

Please describe any important illnesses, injuries or surgeries:-

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Current medical diagnoses / conditions: (ADHD, Autism, CP etc):

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____

Current medication prescribed:

____

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3. Developmental Milestones & abilities

Approximate age at which your child:

Raised Head:

Rolled:

Sat alone:

Crawled on hands and knees:

Pulled to stand:

Stood alone:

Walked:

Your general impression of your child's motor development: (tick as appropriate)

	Advanced	Normal	Slow
Gross motor (running, jumping ball play)			
Fine motor (manipulation of objects with hands)			
Handwriting & colouring skills			

Favourite indoor play?

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____

Favourite outdoor play?

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____

What are your child's strengths?

____

____

General behaviour (tick as appropriate)

	Never	Sometimes	Usually	Always	Unsure
Does your child tire easily during activities?					
Does your child appear fearful of movement or heights?					
Is your child impulsive?					
Is your child easily upset by failure?					
Is your child able to relate to peers?					
Is your child negative about their own ability?					
Is your child able to organise themselves and their belongings?					
Does your child have difficulty making friends?					
Does your child's behaviour appear the same at home and school?					

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Mealtime ability (tick as appropriate)

	Never	Sometimes	Usually	Always	Unsure
Feed themselves (age appropriate)					
Good appetite / eats all food groups					
Messy eater					
Food preferences determined by texture, taste, smell					

Dressing ability (tick as appropriate)

	Never	Sometimes	Usually	Always	Unsure
Independent for age					
Can do up buttons					
Can put on socks					
Can put on shoes					
Can tie laces					
Needs prompts to keep on task					

Toilet / washing / personal hygiene (list difficulties – bath, shower, tooth brushing, toileting)

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Sensory & behaviour (tick as appropriate)

	Never	Sometimes	Usually	Always	Unsure
Transitions smoothly between tasks					
Reacts appropriately to external noises/distractions					
Reacts appropriately to different textures					
Appears to recognise objects by touch, manage small objects such as buttons					
Appears to sense where head and body are in space; can move easily through space without falling or running into people/objects					
Maintains postures (sitting or standing without slumping, moving around restlessly or bouncing)					
Demonstrates self-control					
Shows safety awareness as appropriate for their age					
Uses personal space appropriately, does not intrude on space of others					
Takes turns during games and activities					
Does not get over-aroused; maintains controlled behaviour					

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4. Concerns for your child

Areas of concern: (tick as appropriate)

Fine motor		Handwriting		Over/ under active	
Motor weakness		Muscle tone		Over sensitive / under responsive	
Feeding		Endurance		Sensory processing	
Dressing		Attention / distractibility		Toileting	
Play skills					

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Please describe any of these concerns that have been checked and detail any other concerns you may have:

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What would you like us to help you and your child with?

____

Is your child currently receiving any therapy or involved in any special programs?

____

What other evaluations, therapy or special programs has your child had in the past?

____

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5. Summary

Are there any other concerns or comments you feel would be helpful for us to understand your child better?

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Thank you very much for your time and effort.

PLEASE USE THIS SPACE FOR ANY ADDITIONAL INFORMATION

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