Occupational Therapy for Children
'Putting the pieces together'

A: 254 Waymouth Street Adelaide SA

Parent Questionnaire (3+ years)

Date Form Completed			
Child's Name	Surname	First Name	Middle Initial
Date of Birth	DD/MM/YYYY		
Parent's/ Carers Name	Mother/ Carer	Father / Carer	
Address			
Email Address			
Phone Details	Mobile	Home	Work
Private Health Care	Fund Name	Member Number	
NDIS Funding	NDIS Number		
Medicare Card Details	Number	Parent No. Child No.	Valid to date
Medicare Funding (circle)	EPC / CDM	FPS / Mental Health Care Plan	Autism Initiative A135
Place in Family (names & ages of siblings			
Childcare / Kindy / ELC / School Name			
Year Level			
Teacher's Name			
Referred By:			
Referrer Concerns			
Parent Concerns			

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. Thank you for your assistance.

The OTFC Assessment Team

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Does your Child have a Medical diagnosis (tick)

Autism Spectrum Disorder ❒

Genetic Disorder ❒

Cerebal Palsy ❒

Other ❒ ____

Please submit Report / information of diagnosis to admin@otfc.com.au

Medical history (colic, allergies, eczema, ear infections, asthma, sinus, seizures)

Current Paediatrician (name / contact)	
Family GP (involved) (name/contact)	
Current Medication	
Hearing (concerns/tests/results)	
Vision (concerns/tests/results)	

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Previous/ongoing interventions (tick and list service provider)

Speech Pathologist	
Psychologist	
ABA therapist	
Physiotherapist	
Hydrotherapist	
Biodmedical	
D.I.R. Floortime	
Dietary (e.g. Gluten free)	
RDI Therapy	
Chelation Therapy	
Other	

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? Yes ❒ No ❒

If YES, please provide details

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Speech and language Development

Does your child communicate verbally? Yes ☐ No ☐

Is your child able to follow simple instructions? Yes ☐ No ☐

Does your child use a communication aid to support communication? Yes ☐ No ☐

If YES, please describe ______________________________

Can your child answer a questions using 1-2 word answers? Yes ☐ No ☐

Can your child answer questions using sentences? Yes ☐ No ☐

Physical and Motor Development

Birth/neonatal history (e.g. full term; unusually quick birth; blueness, jaundice, illness, Apgar rating)

Milestones (age when)

Sat	
Crawled correctly	
Walked	
Spoke First Word	
Spoke in Sentences	

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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**	**Unsure**
Appears coordinated in outdoor physical activities					
Prefers gross motor activities					
Maintains posture (play on floor/ table/ standing)					
Clearly uses L or R hand/foot (please circle)					
Rides bike -push/tricycle/trainer wheels/two-wheeler (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**	**Unsure**
Prefers indoor play					
Prefers fine motor play					
Creates own play well					
Plays with blocks, construction items					
Plays with cars, trains					
Plays with puzzles					
Plays with scissors, drawing, painting activities					
Engages in imaginative play					
Plays on the computer					

PLAY	
Favourite Indoor Play	
Favourite Outdoor Play	
What is your home outdoor equipment?	
Extracurricular/community/ group activities? (e.g. drama, swimming, dancing, music)	

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MEALTIMES	Never	Sometimes	Usually	Always	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	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	Unsure
Bath (participates well)					
Showers (participates well)					
Washing face (participates well)					
Washing hair (participates well)					
Hair brushing (participates well)					

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SLEEP	Never	Sometimes	Usually	Always	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					

What time does your child wake in the morning?	am
Does your child need a daytime sleep?	Yes ❒ No ❒
What time does your child go to bed at night?	pm
How long does it take to go to sleep?	

TOILET	Never	Sometimes	Usually	Always	Unsure
Bladder control - day					
Bladder control - night					
Bowel control - day					
Bowel control - night					
Dressing					
Pressing button					
Washing Hands					

BEHAVIOUR pattern/reactions - current	Never	Sometimes	Usually	Always	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					

BEHAVIOUR pattern/reactions - when very young	Never	Sometimes	Usually	Always	Unsure
Needed/demanded lots of attention/activity when awake?					
Passive, looker					
Needed much holding/ moving/ stroking/ tapping/ to settle?					
Coped with change of routine?					
Had feeding or digestive problems?					

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TOUCH (Tactile)	Never	Sometimes	Usually	Always	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	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**	**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	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**	**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**	**Unsure**
Is particularly sensitive to smells					
Seeks out certain smells / sniffs things					

General demeanour (How would you describe your child's nature?):

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Privacy Permission Form

Name of Child	
Date	
Name of Parent	
Signature of Parent	

I give consent to OTFC to discuss and send relevant information regarding my child with the following professionals:

	Email	Phone
Childcare/Kindy/School		
Paediatrician		
Speech Pathologist		
Psychologist		
Other		
Other		

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