Parent Questionnaire

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Note: This form can be completed electronically or by hand.

Please fill out this questionnaire as accurately as you can, completing all questions. If you are unsure about any of the questions, ask your therapist to clarify. All information collected will be kept private and confidential.

Person completing questionnaire | *Relationship to client* | *Date*

Child's Name | **DOB**

Preferred Name | **Gender**

Address Line 1

Address Line 2

Suburb + State | **Post code**

Day-care / Kindy / School | **Grade** | **Teacher**

Mother's Name | **Occupation**

Contact No. | **Email**

Father's Name | **Occupation**

Contact No. | **Email**

Siblings + Ages *(if applicable)*

Diagnosis *(if applicable)*

Funding

NDIS ☐ If yes: ☐ Self-managed ☐ Plan-managed ☐ NDIA managed

Medicare ☐

Health Fund ☐ Health Fund Provider:

Privately ☐

NDIS Number *(if applicable)*

NDIS Plan Manager Details *(if applicable)*

Plan Manager's Name

Plan Manager's Phone

Plan Manager's Email

Plan Manager's Agency/ Organisation

Support Coordinator/LAC Details *(if applicable)*

Support Coordinator/LAC's Name

Support Coordinator/LAC 's Phone

Support Coordinator/LAC's Email

Support Coordinator/LAC's Agency/ Organisation

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Parent Questionnaire *CONTINUED*

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Specialist(s) involved *(Please list)*

- ☐ General Practitioner (GP) _____
- ☐ Paediatrician _____
- ☐ Psychologist _____
- ☐ Speech Language Pathologist _____
- ☐ Other _____

Medications *(Please list if applicable)*

_____

_____

Please list your main concerns here

List your child's STRENGTHS here

List your child's DIFFICULTIES here

List any SPECIAL INTERESTS or FAVOURITE ACTIVITIES your child has here

List THREE SKILLS you would like your child to improve

1.
2.
3.

What are you hoping to get out of occupational therapy + from your occupational therapist?

Do you have a good understanding of what occupational therapy is and what it can do for your child?

☐ Yes ☐ No

Would you like more information?

☐ Yes ☐ No

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Parent Questionnaire *CONTINUED*

Prenatal and Birth History

How long was the pregnancy? _____ weeks Birth weight _____

Any complications during birth? _____

IMMEDIATELY FOLLOWING THE BIRTH

Did the infant have trouble starting to breathe? ☐ Yes ☐ No Was infant blue? ☐ Yes ☐ No

Did infant have sucking or swallowing difficulty? ☐ Yes ☐ No Jaundice? ☐ Yes ☐ No

Feeding problems? ☐ Yes ☐ No Seizures? ☐ Yes ☐ No

Any other conditions or illnesses? ☐ Yes ☐ No

If yes: _____

How would you describe your infant's temperament, feeding, sleeping habits and ability to self-calm?
(easy going, high maintenance, colicky, needed dummy/swaddling/rocking to calm down)

DURING FIRST 3 MONTHS:

BETWEEN 4-12 MONTHS:

Developmental History

APPROXIMATE AGE WHEN CHILD

Rolled over _____	Sat without support _____	Slept through the night _____
Began to crawl _____	Cruised along furniture _____	Walked without assistance _____
Toilet trained _____	Bladder (day) _____	Bladder (night) _____
	Bowel (day) _____	Bowel (night) _____
Other _____	Dressed themselves _____	Used a spoon for feeding _____
Does the child seem to have a dominant hand? _____		If yes, which hand? _____

Speech and Oral Motor History

DID YOUR CHILD HAVE ANY OF THE FOLLOWING DIFFICULTIES

Nursing or taking a bottle ☐ Yes ☐ No Reflux ☐ Yes ☐ No

Transitioning to baby food ☐ Yes ☐ No Eating solid foods ☐ Yes ☐ No

Drinking from a cup ☐ Yes ☐ No Using a straw ☐ Yes ☐ No

Chewing or swallowing food ☐ Yes ☐ No Tolerating a variety of food textures & tastes ☐ Yes ☐ No

DOES YOUR CHILD HAVE ANY DIAGNOSED SPEECH OR LANGUAGE DELAYS, OR DO YOU HAVE ANY CONCERNS?

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Parent Questionnaire *CONTINUED*

Health History

Have you had your child's vision tested in the past 24 months? ☐ Yes ☐ No If no, when? _____

Does your child wear glasses? ☐ Yes ☐ No

Have you had your child's hearing tested in the past 24 months? ☐ Yes ☐ No If no, when? _____

Illness/Surgeries	Age	Mild, Average, Severe	Hospitalisation	Year
Ear infections				
High fevers				
Bronchitis/Pneumonia				
Tonsillitis/Tonsillectomy				
Allergies				
Seizures				
Other				

Did you notice any changes in your child's level of function (speech, cognition, motor skills) after any of the above? If so, please describe:

Areas of Difficulty

PLEASE TICK THE AREAS YOUR CHILD HAS DIFFICULTY REGARDING ***SELF CARE:***

- ☐ Dressing *(i.e. zips, buttons, etc)*
- ☐ Toileting
- ☐ Restricted diet/eating
- ☐ Utensil use *(i.e. knife, fork, scissors, cutting, etc)*
- ☐ Managing a lunch box/ materials *(i.e. opening packaging)*
- ☐ Household chores
- ☐ Teeth brushing
- ☐ Showering

PLEASE LIST OTHER AREAS YOUR CHILD HAS DIFFICULTY WITH THAT ARE NOT LISTED:

PLEASE TICK THE AREAS YOUR CHILD HAS DIFFICULTY REGARDING ***ATTENTION/ORGANISATION:***

- ☐ Completing tasks
- ☐ Task persistence
- ☐ Following and attending to instructions
- ☐ Getting ready for school
- ☐ Organising belongings
- ☐ Managing belongings

PLEASE LIST OTHER AREAS YOUR CHILD HAS DIFFICULTY WITH THAT ARE NOT LISTED:

PLEASE TICK THE AREAS YOUR CHILD HAS DIFFICULTY REGARDING ***SOCIAL SKILLS / RELATIONSHIPS / EMOTIONS:***

- ☐ Relationships with family
- ☐ Friends
- ☐ Managing teacher relationships
- ☐ Managing/understanding emotions

PLEASE LIST OTHER AREAS YOUR CHILD HAS DIFFICULTY WITH THAT ARE NOT LISTED:

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Parent Questionnaire *CONTINUED*

Areas of Difficulty *CONTINUED*

PLEASE TICK THE AREAS YOUR CHILD HAS DIFFICULTY REGARDING ***ACADEMIC AREAS:***

- ☐ Handwriting/prewriting
- ☐ Behaviour at school
- ☐ Organising belongings
- ☐ Organisation
- ☐ Spelling
- ☐ Maths
- ☐ Knowledge of numbers, concepts, etc
- ☐ Attention/ability to stay on task

PLEASE LIST OTHER AREAS YOUR CHILD HAS DIFFICULTY WITH THAT ARE NOT LISTED:

PLEASE TICK THE AREAS YOUR CHILD HAS DIFFICULTY REGARDING ***PLAY/LEISURE:***

- ☐ Persisting at play
- ☐ Entering/joining play
- ☐ Developing interests
- ☐ Able to make and keep friends
- ☐ Participating in sports or other physical activities
- ☐ Following the rules/expectations of play
- ☐ Keeping up with peers in play or leisure

PLEASE LIST OTHER AREAS YOUR CHILD HAS DIFFICULTY WITH THAT ARE NOT LISTED:

General Information

About how much exercise does your child get every day?

☐ Less than 30 minutes ☐ 30 mins to 1 hour ☐ More than 1 hour

About how many hours of TV does your child watch every day?

☐ Less than 1 hour ☐ 1 to 3 hours ☐ More than 3 hours

About how many hours is your child on a computer/tablet every day?

☐ Less than 1 hour ☐ 1 to 3 hours ☐ More than 3 hours ☐ Does not have one

About how many hours are spent reading with your child every day?

☐ Less than 15 minutes ☐ 15 to 30 mins ☐ 30 mins to 1 hour ☐ More than 1 hour

About how many hours does your child spend outside every day?

☐ Less than 1 hour ☐ 1 to 3 hours ☐ More than 3 hours

Anything else we should know about?

How did you find out about us?

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