PARENT / CARER PRE-ASSESSMENT QUESTIONNAIRE

The information provided in this questionnaire will assist your Occupational Therapist to plan for assessment and treatment sessions, making best use of the assessment time. Please provide as much information as you can.

Once we receive your completed form, we will be in touch to offer you an appointment time, or will advise you of our waiting list.

<table>
<tr><td>Child's name</td><td colspan="5">x</td></tr>
<tr><td>Date of birth</td><td>/ /</td><td>Age</td><td>x</td><td>Gender</td><td>x</td></tr>
<tr><td>Your full name</td><td>x</td><td colspan="2">Relationship to child</td><td colspan="2">x</td></tr>
<tr><td>Child's school</td><td>x</td><td colspan="2">Child's teacher</td><td colspan="2">x</td></tr>
<tr><td>GP</td><td>x</td><td colspan="2">GP Contact</td><td colspan="2">x</td></tr>
<tr><td colspan="6">HISTORY</td></tr>
<tr><td>Has your child received any diagnoses?</td><td colspan="5">x</td></tr>
<tr><td>If so, when were they diagnosed?</td><td colspan="5">x</td></tr>
<tr><td>Is there any family history of these or other diagnoses?</td><td colspan="5">x</td></tr>
<tr><td>Any allergies / hearing / vision difficulties</td><td colspan="5">x</td></tr>
<tr><td colspan="6">PREGNANCY</td></tr>
<tr><td>Account of pregnancy (gestation, complications etc)</td><td colspan="5">x</td></tr>
<tr><td colspan="6">DID YOUR CHILD EXPERIENCE DIFFICULTY ACHIEVING THE FOLLOWING MILESTONES?</td></tr>
<tr><td>Early Development
(eg head control, rolling, sitting, crawling, walking)</td><td colspan="5">x</td></tr>
<tr><td>Gross Motor
(eg running, jumping, throwing, catching)</td><td colspan="5">x</td></tr>
<tr><td>Fine Motor
(eg holding a pencil, using scissors & cutlery)</td><td colspan="5">x</td></tr>
<tr><td>Social & Communication
(eg talking, eye contact, gestures)</td><td colspan="5">x</td></tr>
<tr><td colspan="6">REASON FOR SEEKING OCCUPATIONAL THERAPY</td></tr>
<tr><td>What are your / the teacher's main concerns regarding your child?</td><td colspan="5">x</td></tr>
<tr><td>What would you like your child to achieve?</td><td colspan="5">x</td></tr>
<tr><td>What are your child's strengths?</td><td colspan="5">x</td></tr>
<tr><td>What are your child's interests and favourite activities or characters?</td><td colspan="5">x</td></tr>
</table>

DO YOU HAVE CONCERNS REGARDING THE FOLLOWING?			
FINE MOTOR SKILLS Such as handwriting, managing scissors, cutlery, shoelaces & buttons	x	**GROSS MOTOR SKILLS** Such as running/jumping/ catching a ball, learning new movements	x
MOVEMENT & BALANCE May be clumsy, bumps into things, lack confidence in movements	x	**ORGANISATIONAL SKILLS** Difficulty caring for belonging, paying attention, following instructions	x
SENSORY PROCESSING Over- or under-sensitive to sound/touch; can't sit still; distracted	x	**MEALTIME BEHAVIOURS** Such as fussy eating/ avoidance of new foods/ gags with food or smells	x
SOCIAL SKILLS Difficulty in playing with peers/turn taking/making friends; excessive shyness	x	**EMOTIONAL REGULATION** May exhibit tantrums/ anxiety/frustration/ separation difficulties	x
SELF CARE SKILLS Feeding, dressing, toileting, brushing teeth & hair, managing buttons	x	**DAILY ROUTINE** Such as sleep patterns, attending school, enjoying activities, attending shops	x

HAS YOUR CHILD HAD INVOLVEMENT WITH ANY OF THE FOLLOWING HEALTH PROFESSIONALS:
Paediatrician, Psychologist, Speech Pathologist, Physiotherapist, Dietician, Occupational Therapist

Discipline	Reason	Last seen
X	x	x
X	x	x
X	x	x

ANY OTHER COMMENTS?
X

Please email the completed form to Admin@FacilitateOT.com.au or fax to 02 4201 0196