PARENT QUESTIONNAIRE

INFORMATION ABOUT YOUR CHILD

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The following details will be recorded and stored as part of a confidential occupational therapy file

Child's Full Name:

Preferred Name:

Date of Birth:

Address:

Indigenous status:

School:

School Year Level:

Class Teacher/s:

Class Teacher email contact:

Parent/Carer 1 Name:

Address (if different to above):

Relationship to Child:

Indigenous status:

Phone:

Mobile:

Email:

Parent/Carer 2 Name:

Address (if different to above):

Relationship to Child:

Indigenous status:

Phone:

Mobile:

Email:

Are shared care arrangements in place? (Please circle)

Yes / No **If Yes, please provide details** _____

Are all guardians aware of your child's referral for occupational therapy services?

Yes/No **Please describe:** _____

REFERRAL INFORMATION

Please indicate any specific concerns you have about your child's participation at school, home or in the community. Identify any particular tasks your child has more difficulty with than same aged peers.

_____

_____

What impact do these concerns have on your child's life?

_____

_____

Is there anyone else in your family that has/had similar issues? **Yes / No**

_____

HEALTH

Please provide details of GP if you would like copies of reports to go to him/her

GP Name: .....

GP Contact details: .....

Does your child have any significant health problems? **Yes / No**
Please comment: .....
.....

Does your child have any allergies? **Yes / No**
Please comment: .....
.....

Has your child had an assessment of hearing? **Yes / No**
If Yes, please provide details:.....
.....

Has your child had an assessment of eyesight? **Yes / No**

If Yes, please provide details:.....

.....

Is your child on any medication? **Yes / No**

Please specify with dosage: .....

.....

Has your child had any contact in the past with or is currently seeing any of the following?

Service	Y/N	Who	When	Contact Details
Paediatrician				
Occupational Therapist				
Physiotherapist				
Psychologist				
Speech Pathologist				
Optometrist				
Hearing specialist				
Other				

For children **under the age of 6 years**, have you applied to ECEI (a sub-branch of NDIS supporting children under the age of 6 years with developmental delays)?

Yes No (please circle)

Outcome of ECEI referral (please describe) .....

.....

.....

For **school aged children**, has your child got a verified disability through the Department of Education Queensland e.g. Speech Language Impairment, Autism Spectrum Disorder, Physical Impairment, Hearing Impairment, Visual Impairment or intellectual disability?

Yes No (please circle)

Is your child **eligible** for the **National Disability Insurance Scheme** (NDIS)?

Yes No (please circle)

Has your child accessed **Better Access to Mental Health** (BAMH) Care Plan for psychology and/or occupational therapy?

Yes No (please circle)

Outcome of BAMH services (please describe) ……
……
……

Has your child accessed the **Chronic Disease Management** (CDM) Plan through Medicare for any therapy?

Yes No (please circle)

Outcome of CDM services (please describe) ……
……
……

SOCIAL EMOTIONAL

Please describe your child's personality (e.g. shy, happy, easily excited, angry) ……
……
……

Does your child have any favourite activities/toys/games/interests? ……
……
……

Have there been any recent disruptions in family life? **Yes / No**
Please comment:……
……

Does your child:	**Yes/ No**	**Comments**
Play with others?		
Withdraw?		
Prefer a group?		
Have friends at home/school?		
Have trouble making friends?		

Are any of these behaviours causing concern? (Please circle)			
Lack of eye contact	Yes/No	Dislike of changes to routine	Yes/No
Nervous habits	Yes/No	Poor sleep habits	Yes/No
Aggression	Yes/No	Distractibility	Yes/No
Excessive tantrums	Yes/No	Becomes frustrated	Yes/No
Obsession about a toy/object/topic	Yes/No	Other (describe)	

EARLY DEVELOPMENT

If you have a report from CDS/Paediatric Outpatients that you are willing to share with us, you do not need to fill this section out

Please comment on mother's pregnancy and your child's birth: .....

.....

When did your child:

	Early	Usual Time	Late	Not sure	Usual Age
Smile					6 weeks
Roll					4-6 months
Sit					6-7 months
Crawl					7-9 months
Walk					12-15 months
Talk (words)					12-18 months
Talk (sentences)					18-24 months

Please comment on any previous or current issues with:

	Please circle		**Please comment**
Feeding (breast/bottle)	Yes	No	
Eating/drinking	Yes	No	
Sleeping	Yes	No	
Toilet training	Yes	No	
Dressing	Yes	No	

Any other information that we should know? .....
.....

Thank you for completing this questionnaire.

Completed by:.....

Relationship to child: .....

Date: .....