Step by Step Occupational Therapy

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To inform our assessment and provide us with an in-depth history of your child's development, please take your time to fill in this questionnaire, with as much detail as possible.

CHILD'S DETAILS:

Child's full name: _____ Date of birth: _____ Age: _____

Country of birth: _____ First language: _____

FAMILY STRUCTURE:

Mother's name: _____ Father's name: _____

Parents' relationship: Married ☐ Separated ☐ Divorced ☐ Not married ☐

If divorced:

1) How much time does your child spend with each parent?
   _____
   _____
2) Is either parent re-married? _____
3) Do parents have similar parenting and disciplining styles? Please elaborate:
   _____
   _____

Names and ages of siblings (if applicable):

_____
_____
_____

Describe your child's relationship with siblings:

_____
_____
_____

Does anyone else live with the family? Yes ☐ No ☐

What is their relationship to the child?

_____
_____

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Please indicate if there is any family history of the following and please elaborate if 'yes':

Learning difficulties: Yes ☐ No ☐ _____

Speech or language delays: Yes ☐ No ☐ _____

Autistic Spectrum Disorder: Yes ☐ No ☐ _____

ADHD: Yes ☐ No ☐ _____

Sensory Processing Disorder: Yes ☐ No ☐ _____

Mental health difficulties: Yes ☐ No ☐ _____

REFERRAL TO OCCUPATIONAL THERAPY:

How do you, as parents, feel regarding the referral?

_____

_____

Who referred your child to O.T.? _____

What is their occupation? Teacher ☐ Doctor ☐ Parent ☐ Physio ☐ Speech pathologist ☐

What was the reason for referral? _____

_____

_____

_____

Has your child received previous intervention (e.g. speech, physio, psychology, extra lessons)?

Yes ☐ No ☐

Please elaborate on the type of intervention, name of therapist, duration of intervention and reason for stopping: _____

_____

_____

_____

PRE-NATAL, BIRTH AND INFANT HISTORY:

Please provide any pertinent information on your pregnancy: (medications; falls; illnesses; etc.)

_____

_____

Length of pregnancy (weeks)? _____

What was your child's weight at birth? _____

Was your child born via: Natural delivery ☐ Emergency / elective Caesarean section ☐

Induced ☐ Forceps/ suction assisted ☐

What were your child's APGAR scores? _____

Did you/the child's mother experience any labour or birth difficulties? Yes ☐ No ☐

If yes, please elaborate:

_____

_____

Was your child admitted to the NICU? Yes ☐ No ☐

If yes, for how long and what was the reason?

_____

_____

Did you/the child's mother experience any postnatal difficulties? Yes ☐ No ☐

Please elaborate: _____

Did you/the child's mother experience postnatal depression? Yes ☐ No ☐

Did your child experience colic? Yes ☐ No ☐ For how long? _____
Was this treated medically or did it resolve naturally? (Please circle which option)

Did your child suffer from reflux? Yes ☐ No ☐ For how long? _____
Was this treated medically or did it resolve naturally? (Please circle which option)

Were you able to breastfeed your child? Yes ☐ No ☐ Did your child latch easily? Yes ☐ No ☐

Did your child feed easily as an infant? Yes ☐ No ☐

Please describe your child as a baby (activity level, degree of curiosity, ability to soothe, etc.)

_____

_____

_____

_____

MEDICAL HISTORY:

Has your child had any of the following? (Please tick all which apply)

Chicken pox ☐ Ear infections ☐ Tonsillitis ☐ Seizures ☐

Allergies ☐ Cleft palate ☐ Hernias ☐ Autoimmune disease ☐

Please provide all pertinent information regarding the above (when, duration, hospitalisations, specifics, etc.):

_____

_____

_____

Please provide all pertinent information regarding operations your child has had (grommets, tonsils, etc.):

_____

_____

_____

Is your child currently taking any medication? Yes ☐ No ☐ If yes, please give names and dosages:

_____

_____

Has your child has their eyes tested? If so, when and by whom? _____

Has your child has their hearing tested? If so, when and by whom? _____

SLEEPING HABITS:

What was your child's sleep routine as an infant? (Hours, regularity, deepness of sleep, etc.)

_____

_____

What is your child's bedtime now? _____ What time does your child wake up? _____

Does your child have difficulty falling asleep? Yes ☐ No ☐

When sleeping, does your child: Have nightmares? Yes ☐ No ☐ Night terrors? Yes ☐ No ☐

DEVELOPMENTAL HISTORY:

At what age (months) did your child:

Gross motor:		**Speech:**		**Activities:**	
Roll	_____	Words	_____	Undress self	_____
Sit	_____	2-word sentences	_____	Dress self	_____
Crawl	_____	3-4 word sentences	_____	Used spoon	_____
Creep	_____	Asked questions	_____	Used knife	_____
Walk	_____			Buttons	_____
Run	_____			Zip	_____
				Laces	_____

How did your child crawl? _____

Please describe how your child toilet trained (age, duration, difficulties, etc) : _____

_____

_____

Please explain if you have noticed that your child is more or less able to play games and join in activities that his/her friends play? _____

_____

_____

SELF CARE:

Is your child independent in the following:

Blowing nose: Yes ☐ No ☐ Putting clothes on correctly: Yes ☐ No ☐

Shoes on correct feet: Yes ☐ No ☐ Fastening buttons: Yes ☐ No ☐

Fastening buckles: Yes ☐ No ☐ Tying shoe laces: Yes ☐ No ☐

Please provide any other relevant information regarding your child's ability to perform self-care tasks

_____

_____

_____

GROSS MOTOR AND PHYSICAL DEVELOPMENT:

Has your child mastered the following:

Monkey bars: Yes ☐ No ☐ Fireman pole: Yes ☐ No ☐

Riding a tricycle: Yes ☐ No ☐ Riding a bicycle with training wheels: Yes ☐ No ☐

Riding a bicycle: Yes ☐ No ☐ Swimming: Yes ☐ No ☐

Is your child clumsy: Yes ☐ No ☐ Does your child have good stamina: Yes ☐ No ☐

Did your child experience any difficulty learning the above? Please elaborate with any relevant details:

_____

_____

_____

FINE MOTOR DEVELOPMENT:

Please indicate your child's hand preference? Right ☐ Left ☐ Unestablished ☐

Does your child:

Use scissors correctly: Yes ☐ No ☐ Hold a pencil/crayon appropriately: Yes ☐ No ☐

Enjoy fine motor activities: Yes ☐ No ☐

Did your child experience any difficulty learning the above? Please elaborate with any relevant details:

_____

_____

_____

ORGANISATIONAL SKILLS

Follow 2-3 step instructions: Yes ☐ No ☐ Approach to tasks organised: Yes ☐ No ☐

Difficulty with puzzles: Yes ☐ No ☐ Any emotional/behavioural concerns: Yes ☐ No ☐

Frustrated easily: Yes ☐ No ☐

Please provide any other relevant information regarding your child's organisational skills

_____

_____

_____

EDUCATION HISTORY:

Please provide your child's school history (including current):

Name of school	Year attended
_____	_____
_____	_____
_____	_____
_____	_____

How have your child's teachers described him/her in the classroom? _____

_____

_____

_____

_____

Does your child enjoy school? Yes ☐ No ☐

Are any of these areas of concern for you or your child or their teacher?

Behaviour: Yes ☐ No ☐ Gross motor skills: Yes ☐ No ☐ Fine motor skills: Yes ☐ No ☐

Friendships: Yes ☐ No ☐ Spatial layout: Yes ☐ No ☐ Task completion: Yes ☐ No ☐

Reading: Yes ☐ No ☐ Maths skills: Yes ☐ No ☐ Handwriting: Yes ☐ No ☐

Focus: Yes ☐ No ☐ Following instructions: Yes ☐ No ☐

Please elaborate on the areas of concern: _____

_____

_____

_____

SOCIAL SKILLS:

Does your child play easily with peers: Yes ☐ No ☐ Can your child play alone? Yes ☐ No ☐

Please describe your child's play (leader, follower, ability to use toys, imagination, indoor vs outdoor; sedentary vs active; etc): _____

_____

_____

_____

_____

Which types of play does your child enjoy (please tick all that apply):

Sporting ☐ Climbing ☐ Imaginative ☐ Drawing ☐

Television ☐ Electronics ☐ Construction ☐ Lego/blocks ☐

How does your child interact with family members? _____

_____

_____

How does your child interact with strangers? _____
_____
_____

PARENT EXPECTATIONS:

What do you consider your child's strengths to be? _____
_____
_____
_____

What makes your child special to you?_____
_____
_____
_____

What do you view your child's difficulties to be? _____
_____
_____
_____

What do you expect from the occupational therapy process? _____
_____
_____
_____

Do you have time at home to do O.T. homework? Yes ☐ No ☐

If so, how much time daily can you commit to (minutes)? 5 ☐ 10 ☐ 15 ☐ 20 ☐

Thank you for taking the time to complete this questionnaire.

Please return it, along with the Sensory Processing Measure, to the Step by Step Occupational Therapy department in person or via e-mail at least three days before your initial meeting with your assessing therapist. If the return of this form is delayed, it may result in a delay of your child's assessment date.

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