

ENABLE

CHILDREN'S OCCUPATIONAL THERAPY AND PHYSIOTHERAPY
IN THE NORTH EAST

www.enabletherapy.co.uk :: enquiries@enabletherapy.co.uk

Parent Questionnaire

1. PERSONAL DETAILS

Child's name:Date of Birth:.....

Address:

.....

Tel No: E mail address:

Parent names and other siblings:.....

.....

.....

School (including telephone number):.....

Head Teacher:.....

Class Teacher:

Learning Support Teacher:.....

2. HEALTH PROFESSIONALS

Please identify the names of any other professionals involved with your child
e.g.

	Previous	Presently	Name/Comments
Occupational Therapist			
Physiotherapist			
Speech Therapist			
Paediatrician			
Psychiatrist			
Psychologist			
Educational Psychologist			
Others (please name) e.g. counsellor			

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Are you happy for us to contact them?

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3. YOUR CHILD'S HISTORY

A) EARLY CHILDHOOD HISTORY

Were there any complications at the birth of your child?

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Was your child born at full term (38-40 weeks)?

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Was your child ever admitted to the special care unit? Yes / No

If so, when and for how long?

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Please describe your child as an infant, e.g. good/irregular sleep patterns, cried a lot, fussy, irritable/non-demanding, liked/resisted being held etc.

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B) PAST MEDICAL HISTORY

Were there any significant childhood illnesses, if so at what age?

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Did your child ever suffer from ear infections?

If so how often and at what age?

Did your child ever have grommets inserted and if so, at what age and for how long?

Does your child take any medicines? ... If yes, please state name and reason;

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.....

Has your child ever had

A) Any fits? If yes please comment.....

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B) Any surgery? If yes please comment
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C) DEVELOPMENTAL HISTORY

Was there any delay in speech and language? If so, please give details.....

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Please indicate, if possible, the date and results of your child's most recent

Hearing Test

Vision Test.....

Approximately at what age did your child do the following:

	Years	Months
Smile		
Roll over		
Sit up		
Bottom shuffle		
Crawl		
Walk		
First words		

At what age did your child show hand preference? (i.e. use of one hand rather than the other).....

D) FAMILY HISTORY

Is there any family history of delay and associated difficulties in the immediate and extended family? (E.g. dyslexia, hyperactivity, learning difficulties, motor problems)

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4. YOUR ASSESSMENT OF YOUR CHILD'S ABILITY

Could you please indicate your child's level of ability in the following areas by ticking the appropriate category where:

1 = Unable to do the task/activity independently

2 = Can do task or activity, but it is of poor quality, or requires great effort, or takes a long time.

3 = Able to do the task with ease

				COMMENTS
Standing on one leg	1	2	3	
Jumping	1	2	3	
Hopping	1	2	3	
Skipping (without rope)	1	2	3	
Running	1	2	3	
Riding a bike (without stabilisers)	1	2	3	
Catching a ball	1	2	3	
Climbing (e.g. steps, climbing frame)	1	2	3	
Swimming	1	2	3	
Swinging on a swing	1	2	3	
Using scissors	1	2	3	

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Using pencil/crayons	1	2	3	
Writing	1	2	3	

5. PLAY

Could you please indicate your child's level of ability in the following areas by ticking the appropriate category where:

1 = Unable to do the task/activity independently

2 = Can do task or activity, but it is of poor quality, or requires great effort, or takes a long time.

3 = Able to do the task with ease

				COMMENTS
Jigsaws	1	2	3	
Constructional Toys (e.g. Lego, Meccano, etc)	1	2	3	
Imaginative and pretend play	1	2	3	
'Messy' play (e.g. finger paints, playdough, etc)	1	2	3	
Drawing and colouring in	1	2	3	
Sticking and pasting	1	2	3	

What is your child's favourite **indoor** play activity?

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What is your child's favourite **outdoor** play activity?

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6. SELF CARE

A) **DRESSING**

Can your child dress/undress independently?

If No, which of these areas are difficult (tick as appropriate):

Putting clothes on in the right order	
Putting the clothes on the right way round	
Managing fastenings	
Buttons	
Zips	
Buckles	
Laces	

How long do they take to dress?

B) **EATING/DRINKING**

Is your child able to:

	Tick as appropriate		Comments
Drink from a cup?	Yes	No	

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Use spoon or fork independently?	Yes	No	
Use a knife and fork together?	Yes	No	
Cut food?	Yes	No	
Pour drinks?	Yes	No	
Open lids of jars/ crisp packets/ yoghurt pots	Yes	No	

C) WASHING/TOILETING

Is your child able to:

	Tick as appropriate		Comments
Take self to toilet?	Yes	No	
Wash hands and face?	Yes	No	
Shower/bath self?	Yes	No	
Clean teeth?	Yes	No	
Comb hair?	Yes	No	

7. BEHAVIOUR AND CONCENTRATION

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Describe your child's personality and behaviour at present. Include variations which occur in different settings (e.g. home and school).

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How does your child get on with other **children**?

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How does your child get on with other **adults**?

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8. ROUTINES

Please comment on how your child deals with the following:

	Comments
Getting ready for school in the morning, e.g. dressing to a deadline, remembering what to put in school bag	
Coping with sudden and unexpected changes in routine	
Able to initiate an activity by him/herself	
Able to make transitions from one routine/ activity to another, e.g. play to homework, going to bed	

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Able to listen to simple instructions and carry them out, e.g. "please get the cheese out of the fridge"	
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9. ORGANISATION OF BEHAVIOUR

	Tick as appropriate			Comments
Can be stubborn, unco-operative and inflexible	No	A little	A lot	
Has sudden and exaggerated emotional tantrums	No	A little	A lot	
Over-sensitive to criticism	No	A little	A lot	
Frequently expresses feeling of failure and frustration	No	A little	A lot	
Shows fear and anxiety when faced with new tasks or routines	No	A little	A lot	
Prefers to play alone or with younger children	No	A little	A lot	
Flits from one activity to another	No	A little	A lot	
Able to take part and be involved in play with other children, e.g. sharing, turn-taking, group interaction	No	A little	A lot	

10. SENSORY RESPONSIVENESS

Please indicate your child's reactions and response to the following sensations.

	Tick as appropriate			Comments
Responds negatively to unexpected or loud noises e.g. dog barking, vacuum cleaner, etc	No	A little	A lot	

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Finds it difficult to concentrate on a task with background noise, such as radio, TV	No	A little	A lot	
Appears to enjoy falling and 'crashing about', sometimes without regard to personal safety	No	A little	A lot	
Dislikes activities where head is tipped backwards or upside down, e.g. having hair washed in the bath, doing somersaults, etc	No	A little	A lot	
Becomes anxious or distressed when feet leave ground, e.g. climbing onto higher surfaces	No	A little	A lot	
Rocks or moves around a lot on a chair or on the floor	No	A little	A lot	
Avoids getting 'messy', e.g. sand, finger paint, glue	No	A little	A lot	
Becomes irritated by certain fabrics and textures, e.g. wool, nylon, labels in clothes	No	A little	A lot	
Can react emotionally and aggressively to unexpected touch	No	A little	A lot	

Does your child attend any clubs or have any particular hobbies?

- Swimming
- Drawing/colouring
- Cycling
- Splash activities
- Computer games
- Gymnastics
- Drama & art
- Horse riding
- Football
- Trampolining
- Other – please

list:

11. SCHOOL

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Does your child's school teacher have concerns regarding your child?

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Does your child need extra help at school in order to do his/her work?

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What type of support is your child receiving at school?

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Do you think your child is making progress in line with his/her ability?

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Does your child go to school happily?

- Yes Mostly Occasionally Rarely

General comments about your child at school:

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12. SUMMARY

What do you see as being your child's strengths?

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What are your main areas of concern about your child?

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What are your expectations from the assessment?

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Any further comments:

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Signed (Parent/Carer) Name

Date

By signing above you are confirming that the information within this form is accurate and that you have read and agreed with the attached terms and conditions.

PLEASE POST COMPLETED QUESTIONNAIRE TO:
Mount Huly Farm House, Ovingham, Prudhoe, Northumberland, NE42 6HQ

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Terms and Conditions

GENERAL:

- Payment for assessment must be made in full before any treatment can commence.
- Payment for treatment sessions must be made on or before the first appointment.
- ENABLE reserve the right to change the treatment programme at any point dependant on how the child is reacting to the therapy. Full details will be provided to the parents in advance should this be necessary
- Cancellations or re-arrangement of sessions should be made more than 24 hours in advance. Failure to do this, including no shows, will be charged at full session rate. There will be no refunds for pre-paid sessions.
- ENABLE reserve the right to cancel the programme in the event of persistent no show / lateness or non co-operation.
- ENABLE will recommend a programme of treatment for your child based on the assessment. Some elements of the recommended programme will be outside the skills of the therapists – for example, speech therapy. It will be responsibility of the parents to initiate any recommendations such as these, and ENABLE cannot be held responsible for any areas that fall outside their experience.

TREATMENT SESSIONS:

- Treatment sessions will be 45 minutes to include activities, preparation, review and planning of homework exercises.
- Please be prompt for your appointment time. If you arrive after the start of your session, this will reduce the amount of time the therapists can spend with your child. This will reduce the effectiveness of the programme.
- Children should be dressed in T-Shirt and Shorts or a Track suit and trainers.
- Homework exercises must be completed in full to aid the success of the programme.
- We expect parents to fully co-operate with the therapists at all times, including completion of any homework exercises in between sessions.
- You agree that you are happy for Enable to send reports securely by email where appropriate

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