Stepping Stones
Paediatric Occupational Therapy Service

# PARENT QUESTIONNAIRE / INTAKE ASSESSMENT FORM

**PERSONAL DETAILS**

| **Child's Full Name:** | | | | | |
|---|---|---|---|---|---|
| **Date of Birth:** | | **Age:** | | **Gender:** | ☐ Male ☐ Female |
| **Caregiver:** | | | | **Contact details:** | |
| **General Practitioner:** | | | | **Contact details:** | |
| **Paediatrician:** | | | | **Contact details:** | |

**SOCIAL HISTORY**

*In order for us to best work with you, we need to know a little about your family, please answer the questions below. If you are unsure how to answer, feel free to leave those sections for our first session.*

| **Are there any formal custody arrangements in place?** | ☐ Yes ☐ No |
|---|---|
| **If YES, please give details:** | |

| **Please provide details of your family: (name, gender, age, half/step siblings)** |
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| **Please provide details of any relevant family medical history: (autism, learning problems, mental health problems)** |
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| **Please provide details of any family history which might impact on your child: (divorce, separation, recent moves)** |
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**ABOUT YOUR CHILD**

| **Favourite toys or activities:** |
|---|
| **Favourite movie or TV characters:** |
| **Favourite movie or TV shows:** |
| **Does your child like active/physical play or quiet/sit down play?** |
| **Does your child prefer playing in large groups or with 1-2 children?** |
| **Does your child enjoy imaginary play? If so, what does he/she like to play?** |
| **What do you see as your child's strengths?** |
| **In one sentence, how would you describe your child?** |
| **Do you have any additional information that will help to better understand your child?** |

## SCHOOL HISTORY

| School Name: | | | | | |
|---|---|---|---|---|---|
| Grade: | | Hand Preference | Right / Left | Have any grades been repeated? | Yes / No |
| Is your child in a special class (specify)? | | | | | |
| What does the teacher say about your child? | | | | | |

## REASON FOR SEEKING OCCUPATIONAL THERAPY

| What are your main concerns regarding your child? |
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| |

| What do you want to achieve for your child by coming to Stepping Stones Occupational Therapy? |
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| Who referred you to Occupational Therapy ? |
|---|
| |

## TREATMENT HISTORY

*Please indicate if your child has received therapy before.*

| Discipline | Name & Location | Reason | Last Seen |
|---|---|---|---|
| Paediatrician | | | |
| Psychologist | | | |
| Speech Pathologist | | | |
| Occupational Therapy | | | |
| Physiotherapy | | | |
| Dietician / Nutritionist | | | |
| Other | | | |

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**BRIEF HISTORY**

| Did you have any problems during pregnancy? | | | ☐ Yes ☐ No | |
|---|---|---|---|---|
| If YES, please give details: | | | | |
| Was the birth? | ☐ Premature ☐ Full Term ☐ Overdue | | Weeks: | |
| Type of delivery: | ☐ Normal ☐ Caesarean ☐ Breech<br>☐ Other | | Details: | |
| Length of labour: | ☐ Normal ☐ Prolonged | | Details: | |
| Did the baby require? | ☐ Oxygen ☐ Tube Fed ☐ Transfusions ☐ NICU/Special Care Nursery | | | |
| Details and duration: | | | | |
| Was your child? | ☐ Breast Fed ☐ Bottle Fed ☐ Both | | How long? | |

**MEDICAL HISTORY**

| Diagnosis: | | | |
|---|---|---|---|
| Medication: | | | |
| How often does your child get sick? | ☐ Frequently ☐ Occasionally ☐ Rarely | | |
| Does your child have any allergies? | ☐ Yes ☐ No | Details: | |

| Has your child experienced any of the following? | |
|---|---|
| ☐ Snoring / mouth breathing? | ☐ Bad breath |
| ☐ Ear infections | ☐ Hyperactivity |
| ☐ Head injury | ☐ Sleep challenges |
| ☐ Fractured limbs | ☐ Family history allergies |
| ☐ Frequent daydreaming | ☐ Eczema / skin rashes |
| ☐ Reflux | ☐ Dark circle (purple shiners) under eyes |
| ☐ Constipation / diarrhoea | ☐ Asthma / respiration problems |
| ☐ Bloating / gas / tummy discomfort | ☐ Other |

| Has your child's hearing been tested? | ☐ Yes ☐ No | Details: | |
|---|---|---|---|
| Has your child's vision been tested? | ☐ Yes ☐ No | Details: | |

| Please list any surgeries or procedures our child has undergone with approximate date: |
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**DIETARY HISTORY**

| Do you have concerns with any of the following? | | |
|---|---|---|
| ☐ Mealtime behaviours | **Details:** | |
| ☐ Dietary variety | **Details:** | |
| ☐ Dietary quality | **Details:** | |
| ☐ Response to new foods | **Details:** | |

**DEVELOPMENTAL HISTORY**

| At what age did your child achieve the following milestones? | | | | | |
|---|---|---|---|---|---|
| Hold head up: | | Sit independently: | | Roll over: | |
| Creep: | | Crawl: | | Stand alone: | |
| Walk independently: | | First word: | | Point: | |
| Wave: | | Hand preference: | | | |

**VISUAL & MOTOR SKILLS**

| Please tick any difficulties your child experiences: | |
|---|---|
| ☐ Using scissors | ☐ Jumping |
| ☐ Playing with small toys | ☐ Using cutlery |
| ☐ Completing puzzles | ☐ Doing shoelaces |
| ☐ Learning to swim | ☐ Holding a pencil |
| ☐ Riding a bike | ☐ Writing / drawing |
| ☐ Catching a ball | ☐ Pumping self on swing |
| ☐ Kicking a ball | ☐ Learning new motor skills |

**SOCIAL EMOTIONAL SKILLS**

| Please tick any difficulties your child experiences: | | | |
|---|---|---|---|
| ☐ Mostly quiet | ☐ Overly active | ☐ Tires easily | ☐ Impulsive |
| ☐ Restless | ☐ Stubborn | ☐ Resistant to change | ☐ Sensitive |
| ☐ Talks constantly | ☐ Fights frequently | ☐ Temper tantrums | ☐ Wets bed |
| ☐ Fearful | ☐ Frustrated easily | ☐ Poor attention | ☐ Perfectionist |
| ☐ Separation difficulties | ☐ Immature | ☐ Overly affectionate | ☐ Anxious |

| Please list any other social emotional difficulties your child experiences: |
|---|
| |

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**SOCIAL HISTORY**

*Please tick the response that best describes your child's behaviour. Add any additional comments where appropriate.*

| Situation/ Behaviour | Frequently | Sometimes | Never | Comments |
|---|---|---|---|---|
| Seems to be in constant motion or is unable to sit still for an activity | ☐ | ☐ | ☐ | |
| Has trouble concentrating or can't stay on task | ☐ | ☐ | ☐ | |
| Seems to always be running, jumping, or stomping rather than walking | ☐ | ☐ | ☐ | |
| Bumps into thing or frequently knocks things over | ☐ | ☐ | ☐ | |
| Reacts strongly to being bumping or touched | ☐ | ☐ | ☐ | |
| Avoids messy play and doesn't like to get hands dirty | ☐ | ☐ | ☐ | |
| Hates having hair washed, brushed or cut | ☐ | ☐ | ☐ | |
| Resists wearing new clothing or is bothered by tags or socks | ☐ | ☐ | ☐ | |
| Distressed by loud or sudden sounds such as a siren or a vacuum | ☐ | ☐ | ☐ | |
| Hesitates to play or climb on playground equipment | ☐ | ☐ | ☐ | |
| Difficulties with balance | ☐ | ☐ | ☐ | |
| Loses place when reading or copying from board | ☐ | ☐ | ☐ | |
| Difficulties tracking objects with eyes | ☐ | ☐ | ☐ | |
| Mood variations, outbursts and tantrums | ☐ | ☐ | ☐ | |
| Avoids eye contact | ☐ | ☐ | ☐ | |
| Has trouble following multistep instructions | ☐ | ☐ | ☐ | |
| Fussy eater, often gags on good | ☐ | ☐ | ☐ | |
| Reacts strongly to smells | ☐ | ☐ | ☐ | |
| High pain threshold | ☐ | ☐ | ☐ | |

**TYPICAL DAY: PLEASE DESCRIBE A TYPICAL WEEKDAY AND WEEKEND FOR YOUR CHILD AND FAMILY**

| | |
|---|---|
| **Weekday:** | |
| **Weekend:** | |