NewLeaf
OCCUPATIONAL THERAPY

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PARENT QUESTIONNAIRE

Your child has been referred to NewLeaf Occupational therapy. It would be helpful for us to know more about your current concerns regarding your child's functional abilities and difficulties. This will help us to make our assessment more accurate and provide appropriate intervention. Your comments can indicate your priorities for any treatment/advice that may be offered.

Please thoroughly go through this form and respond accordingly.

CHILD DETAILS

Name: _____ DOB: _____ Sex: _____

GUARDIAN DETAILS

Name: _____ Relationship: _____ Address: _____

Phone number: _____ Email address: _____

Does your child have a diagnosis of any description?

Please comment: _____

Is your child on any medication (please state):

_____

Pregnancy and birth 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 ☐ Other	**Details:**
Length of labour:	☐ Normal ☐ Prolonged	**Details:**
Did the baby require?	☐ Oxygen ☐ Tube Fed ☐ Transfusions ☐ NICU/Special Care Nursery	
Was your child?	☐ Breast Fed ☐ Bottle Fed ☐ Both	**How long?**

Has there been any significant childhood illnesses or surgery? ☐ Yes ☐ No

Comment: _____

Does your child have any difficulties with eyesight or hearing? ☐ Yes ☐ No

Comment:

EARLY DEVELOPMENTAL HISTORY

At what age did your child achieve the following milestones?		
Head control:	Sit independently:	Roll over:
Crawl:	Stand alone:	Walk independently:
First word:	Wave:	Hand preference:

At what age was your child toilet trained? Day: _____ Night_____

Did your child as an infant have feeding difficulties? ☐ Yes ☐ No

If 'Yes' please comment:

_____

FAMILY 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)
Please provide details of any relevant family medical history: (autism, learning problems, mental health problems)
Please provide details of any family history which might impact on your child: (divorce, separation, recent moves)

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 or plays alone?
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?				

Does your child enjoy school? Please comment:

_____

_____

REASON FOR SEEKING OCCUPATIONAL THERAPY

What are your main concerns regarding your child?
Who referred you to Occupational Therapy?

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

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:

VISUAL & MOTOR SKILLS

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

Does your child have any social or communication difficulties? No ☐ Yes ☐ Please comment

_____

SENSORY PROCESSING AND BEHAVIORAL REGULATION

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	☐	☐	☐	

PERSONAL CARE

Please indicate if you have concerns in any of the following areas:

Check level of performance your child is able to complete:

Dressing Skills:

Child can independently dress self?	Yes	No
Child can zip and button clothing?	Yes	No
Child needs occasional assistance to dress?	Yes	No
Child is starting to push arms through sleeves; legs through pant legs?	Yes	No
Parent dresses child on a daily basis?	Yes	No

Comments:

_____

Feeding Skills:

Do you have concerns about your child's eating habits? Child is a very picky eater will only eat certain foods or textures?

Feeding utensils:

Child uses spoons/forks at every meal?	Yes	No
Occasionally or needs reminders to use utensils?	Yes	No
Never uses utensils.	Yes	No
Child eats an adequate amount of food for his/her age?	Yes	No
Child is willing to sit at table/highchair for all meals.	Yes	No

Comments: _____

Social Interactions:

Does your child play with age appropriate toys? Yes No

Does your child respond when his/her name is called? Yes No

Does your child have difficulties with transitions to new activities/environments? Yes No

Does your child have difficulties with changes in routine? Yes No

Does your child have poor frustration tolerance? Yes No

Does your child have poor safety awareness in the community? Yes No

If your child is upset or angry do they have difficulties calming and coping with anger? Yes No

Comments: _____

Do you have concerns about your child's ability to play with other children? Yes No

Please describe: _____

Please thoroughly go through the agreement below and sign accordingly:

Financial Policy Authorization and Agreement

Assignment of benefits: I hereby authorize payment of medical benefits to NewLeaf Occupational therapy. In the event my medical aid society does not honor this request, I take responsibility for payment of my bill.

Appointment cancellation and rescheduling: I am aware of the cancellation and rescheduling policy that I need to notify my child's therapist by message or call a day before appointment to avoid being charged the full fee of the missed session.

Evaluation and treatment authorization: I hereby authorize NewLeaf Occupational Therapy to evaluate and treat the condition(s) for which I am seeking occupational therapy services through direct access or physician referral.

Authorization for treatment of a minor:

I, _____ (Parent/guardian) authorize the NewLeaf Occupational Therapy to evaluate and treat my child _____ (name of client) and includes my permission to evaluate and treat the above named minor in my absence.

I have read and understood the financial policy for NewLeaf Occupational therapy and agree to these terms:

Guardian Signature: _____ Name: _____

Date: _____

Could you please share any Therapy, medical and / or educational reports?

Thank you very much for your co-operation.