



## Assessment Questionnaire

Please complete this parent questionnaire as best you can, in order to assist our assessment. This provides us with valuable information regarding your child's development and current sensory processing. Please return via email prior to your first appointment with us.

### PERSONAL DETAILS

Child's Full Name \_\_\_\_\_ *Please include surname*

Date of Birth (DOB) \_\_\_\_\_ Age \_\_\_\_\_ Gender: Male \_\_\_\_\_ Female \_\_\_\_\_

Parent 1 Full Names \_\_\_\_\_ Parent 2 Full Names \_\_\_\_\_

DOB \_\_\_\_\_ DOB \_\_\_\_\_

Email: \_\_\_\_\_ Email: \_\_\_\_\_

Mobile: \_\_\_\_\_ Mobile: \_\_\_\_\_

Home Address: \_\_\_\_\_

School /Child Care: \_\_\_\_\_ Year: \_\_\_\_\_

School Address: \_\_\_\_\_

Teacher: \_\_\_\_\_ Teacher's Email: \_\_\_\_\_

Schools Main concerns: \_\_\_\_\_

### REASON FOR REFERRAL

Reason for seeking Occupational Therapy: \_\_\_\_\_

Details of concerns noted and when first observed: \_\_\_\_\_

### SOCIAL HISTORY

Parents' Marital Status      Married      Divorced      Separated      Widowed      Single

Details: (custody etc) \_\_\_\_\_

Has any family member had any medical problems? (Specific learning difficulties, autism, behaviour) Yes      No

Please specify: \_\_\_\_\_

Relation to child: \_\_\_\_\_

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## MEDICAL HISTORY

GP Name: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_

Tel/Fax: \_\_\_\_\_ Medicare No./IRN: \_\_\_\_\_

Medications: \_\_\_\_\_

Professional Services: (name and date of last assessment/treatment and diagnosis) \_\_\_\_\_

Paediatrician: \_\_\_\_\_ Email: \_\_\_\_\_

Educational Psychologist: \_\_\_\_\_ Email: \_\_\_\_\_

Speech/Language Therapist: \_\_\_\_\_ Email: \_\_\_\_\_

Physiotherapist/Occupational Therapist: \_\_\_\_\_ Email: \_\_\_\_\_

Other: \_\_\_\_\_

## PLEASE INCLUDE REPORTS

Has your child had an eye evaluation? Yes No By Whom: \_\_\_\_\_

Date: \_\_\_\_\_ Results: \_\_\_\_\_

Has your child had a hearing test? Yes No By Whom: \_\_\_\_\_

Date: \_\_\_\_\_ Results: \_\_\_\_\_

## BIRTH HISTORY

Did you have any problems during pregnancy Yes No

If YES please provide details: \_\_\_\_\_

Was the birth: Premature Full Term Overdue Weeks: \_\_\_\_\_

Type of delivery: Natural Caesarean Breech Other Details: \_\_\_\_\_

Length of Labour Normal Prolonged Details: \_\_\_\_\_

Did your baby require? Oxygen Tube Feeding Transfusions NICU

Please provide details and duration: \_\_\_\_\_

Feeding Breast Fed Yes No Duration \_\_\_\_\_ Bottle Fed Yes No Duration \_\_\_\_\_

Describe your child as a baby:

passive	fussy	cried a lot	good sleep patterns	floppy when held
active	alert	non-demanding	irregular sleep patterns	tense when held
quiet	irritable	good/easy	liked being held	resisted being held

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## DEVELOPMENTAL HISTORY

Held head up: \_\_\_\_\_ Sit up independently: \_\_\_\_\_ Crawled: \_\_\_\_\_

Roll Over: \_\_\_\_\_ Stand Alone: \_\_\_\_\_ Walk Alone: \_\_\_\_\_

Rode a bike: \_\_\_\_\_ Show hand preference: \_\_\_\_\_ Shoelaces/buttons: \_\_\_\_\_

First words: \_\_\_\_\_ Use of knife and fork: \_\_\_\_\_

Are there any other physical factors, past or present, affecting your child's motor development? Yes No

Please provide details: \_\_\_\_\_

Has your child had any problems affecting his/her motor development? Yes No

Please provide details: \_\_\_\_\_

Does your child have difficulties with fine and gross motor skills? Yes No

Please check all difficulties that may apply below:

Hand dominance not established

Difficulties riding a bike

Difficulties learning a new task

Difficulties with fine motor tasks

Difficulties with using scissors

Difficulties with catching a ball

Clumsy/awkward gross motor skills

Bumps or knocks things frequently

## Activities of Daily Living:

Sleep \_\_\_\_\_

Grooming/Dressing: \_\_\_\_\_

Toileting: \_\_\_\_\_

Eating: \_\_\_\_\_

Please continue on the next page.

# Assessment Questionnaire



## SENSORY PROCESSING FUNCTIONS

Please check the response that best describes your child's behaviour. Add any additional comments where appropriate. Also include your child's strengths. If you are unable to answer some questions please leave blank. Use the following to determine the answer.

1 Almost Always	2 Frequently	3 Occasionally	4 Seldom	5 Almost Never
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AUDITORY / HEARING	1	2	3	4	5
1. Responds negatively to unexpected or loud noise (eg. Vacuum cleaner, dog barking)					
2. Is distracted or has trouble functioning if there is a lot of noise around					
3. Seems confused as to direction of sound					
4. Enjoys strange noises / seeks to make noise					
5. Enjoys music					
6. Appears not to hear what you say					

COMMENTS: \_\_\_\_\_

VISUAL PROCESSING	1	2	3	4	5
1. Looks carefully or intently at people					
2. Happy to be in the dark					
3. Gets lost easily					
4. Hesitates going up or down kerbs					
5. Expresses discomfort at bright lights					
6. Puts puzzles together easily					
7. Has a hard time finding objects in competing background (eg. favourite toy in the toy box)					
8. Has trouble staying within the lines when colouring or when writing					

COMMENTS: \_\_\_\_\_

TASTE/SMELL	1	2	3	4	5
1. Acts as though all food tastes the same					
2. Shows preference for certain tastes (please list below)					
3. Craves certain foods (please list below)					
4. Dislikes certain foods or textures					
5. Chews / licks on non-food objects					
6. Deliberately smells objects					
7. Shows preference for certain smells (please list below)					

COMMENTS: \_\_\_\_\_

# Assessment Questionnaire

TOUCH	1	2	3	4	5
1. Avoids getting hands messy (eg. Paste, sand, paint)					
2. Becomes upset when being washed					
3. Expresses distress over having hair cut, combed or washed					
4. Expresses distress over being bathed, having finger nails cut					
5. Prefers long sleeve clothing, sweaters, or jackets even when it is warm					
6. Expresses discomfort when people touch: even in friendly hug or pat					
7. Expresses discomfort when getting teeth brushed					
8. Expresses unusual need for touching certain toys, surfaces or textures					
9. Is sensitive to certain fabrics; avoids wearing clothes made of them					
10. Avoids going barefoot, especially in sand or grass					
11. Avoids wearing shoes; loves being barefoot					
12. Tends to feel less pain than others					
13. Tends to feel more pain than others					
14. Isolates him/herself from other children /people					

COMMENTS: \_\_\_\_\_

MOVEMENT	1	2	3	4	5
1. Becomes anxious or distressed when feet leave the ground					
2. Fears falling or heights					
3. Dislikes activities where head is upside down (eg. Somersault) or rough play					
4. Avoids playground equipment or moving toys					
5. Rocks unconsciously during other activities (eg. whilst watching television)					
6. Avoids climbing, jumping, bumpy or uneven ground					
7. Seeks out all kinds of movement activities (eg. being whirled by an adult, merry-go-rounds)					
8. Takes risks during play (eg. Climbs high into a tree, jumps off tall furniture)					
9. Dislikes riding in a car					

COMMENTS: \_\_\_\_\_

BODY POSITION	1	2	3	4	5
1. Seems to have weak muscles					
2. Tires easily, especially when standing or holding a particular body position					
3. Walks on toes					
4. Holds body in strange positions for periods of time					
5. Locks joints for stability(eg. elbows, knees)					

COMMENTS: \_\_\_\_\_

# Assessment Questionnaire

## SOCIAL AND EMOTIONAL SKILLS

Describe your child at present

mostly quiet	overly active	tires easily	talks constantly
impulsive	restless	stubborn	is resistant to change
over-reacts	fights frequently	is usually happy	has frequent temper tantrums
falls often	poor attention span	has difficulties learning a new task	has difficulties separating from mother/father
sensitive to criticism	has trouble 'growing up'	likes to mix with other children	

Does your child have any social and emotional difficulties Yes No

Please provide details:

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Please provide us with any other detail and information you feel necessary:

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How did you hear about us? \_\_\_\_\_

Completed by: \_\_\_\_\_ Date: \_\_\_\_\_

Thank you for taking the time to complete this form.





## Consent Form

In Sync Kids Occupational Therapy needs to collect information about you for the primary purpose of providing a quality service to you. In order to thoroughly assess and provide therapy, we need to collect some personal information from you. If you do not provide this information; we may be unable to treat you.

This information will also be used for:

- a. The administrative purpose of running the practice;
- b. Billing either directly or through an insurer or compensation agency;
- c. Use within the practice if discussing or passing your child's case to another practitioner within the practice for their ongoing management;
- d. Disclosure of information to your doctors, other health professionals or to teachers to facilitate communication and best possible care for you and your child; and

In Sync Kids Occupational Therapy has a Privacy Policy that is available on request and is available in the waiting area. That policy provides guidelines on the collection, use, disclosure and security of your information. The Privacy Policy contains information on how you may request access to, and correction of, your personal information and how you may complain about a breach of your privacy and how we will deal with such a complaint.

To ensure the process of quality treatment provision, information about your assessment results and progress may be given to relevant other service providers, who are involved in your child's management. These may include your child's doctor, specialists, teacher, carers or insurers.

I (name of parent/ guardian), ....., have read the above information and understand the reasons for the collection of my child's personal information and the ways in which the information may be used and disclosed and I agree to that use and disclosure.

- I understand that it is my choice as to what information I provide and that withholding or falsifying information might act against the best interests of my child's assessment and therapy progress.
- I am aware that I can access my child's personal and treatment information on request and if necessary, correct information that I believe to be inaccurate.
- I have been provided with or have been given an opportunity to obtain a copy of In Sync Kids Occupational Therapy privacy policy.

Signed.....

Date.....

Thank you for taking the time to complete this form.



## Media Form

In Sync Kids Occupational Therapy occasionally take photos during your child's therapy sessions. Sometimes these images may be used to record your child's therapy progress within their clinical file at In Sync Kids Occupational Therapy.

At times, we also like to post images to our Social Media channels to showcase our rooms or therapy services. In Sync Kids Occupational Therapy would like to see your permission to use images of your child in this event. All personal details including your child's name and contact details are strictly confidential and will not be available on these channels.

All images will be stored and disposed of in accordance with the Privacy Act (1988 - Commonwealth)

Parent or Guardian Name (if child is under 18 years of age): \_\_\_\_\_

Child's Name: \_\_\_\_\_

Signature of Parent or Guardian: \_\_\_\_\_

## Risk Acknowledgment and Waiver Form

Child's Name: \_\_\_\_\_

Parent or Guardian Name (if child is under 18 years of age): \_\_\_\_\_

You understand that:

There are inherent risks associated with the use of the equipment in the Occupational Therapy services provided by In Sync Kids Occupational Therapy which may result in personal injury (even of a serious nature) to the Participant and that you fully accept and agree to bear those risks. Prior to you, or the Participant, participating in any use of this equipment within In Sync Kids Occupational Therapy, you should ensure that you are aware of all the risks involved, including those risks associated with any condition that you, or the Participant, may have.

This form may be signed by the Participant, if the Participant is 18 years of age or over or by the parent or legal guardian of the Participant if the Participant is under 18 years of age.

Signature of Parent or Guardian:

Date :

Thank you for taking the time to complete this form.





## Personal and Health Information Collection Statement

In Sync Kids Occupational Therapy is an independent practice under the ownership of Carlyn Cooper.

You may contact In Sync Kids Occupational Therapy by writing to In Sync Kids Occupational Therapy, 1A, 155 Baroona Road by emailing [admin@insynckidsot.com](mailto:admin@insynckidsot.com) or by calling Carlyn Cooper - 07 3184 5997. You have the right to gain access to the information held by In Sync Kids Occupational Therapy about you.

Our Privacy Policy (available upon request) contains information on how you may request access to, and correction of, your personal information and how you may complain about a breach of your privacy and how we will deal with such a complaint.

Collection of Client information:

- In Sync Kids Occupational Therapy needs to collect information about you and your child for the primary purpose of providing quality treatment.
- In order to fully assess and treat you and your child, we need to collect some personal information from you.
- This information will also be used for the administrative purposes of running the practice such as billing you or through an insurer or compensation agency.
- Information will be used within the practice for handover if another practitioner provides you with assistance.
- Client information is stored securely and only practice staff has access to it.
- In Sync Kids Occupational Therapy takes all reasonable steps to ensure that information collected about you and your child is accurate, complete and up-to-date
- You may have access to your information on request and if you believe that any of the information is inaccurate, we may be able to amend it accordingly.

**Disclosure of client information:**

- In Sync Kids Occupational Therapy may disclose information regarding assessments or treatment to your Doctor or other health providers only with your consent.
- In the case of insurance claims, it may be necessary to disclose information and/or collect information that affects your treatment.
- In Sync Kids Occupational Therapy will not disclose your information to commercial companies, however specific services or product information as supposed suitable for your management, may be forwarded to you by us, unless you instruct In Sync Kids Occupational Therapy not to forward this type of information.
- Your written consent will be obtained at the start of your treatment in order to carry out the above activities. We do not disclose your personal information to overseas recipients.

If you do not provide relevant personal or health information, in part or in full, to In Sync Kids Occupational Therapy it may result in incomplete assessment. This may impact the following therapy that is provided.

Any concerns that you may have about this statement or about your management can be directed to Carlyn Cooper, 1A, 155 Baroona Road, Paddington, 4064, or Tel. 07 3184 5959

Thank you for taking the time to complete this form.