Parent/Guardian/Carer Questionnaire

In order to maximise your practical assessment time in clinic we would be grateful if you could take the time to fill out this questionnaire.

If you are unsure of any questions, please speak with one of our team who will be able to assist.

Thank you.

Basic Information

Child's First Name: _____. Surname: _____

Likes to be called: _____

Date of Birth: _____

Home Address: _____

_____ Post code: _____

Email: _____

Home Phone No.: _____

Mobile Phone No.: _____

Your Name: _____

Your Partner's Name: _____

Carer's Name: _____

Siblings: _____

(names and ages) _____

School Name: _____

School Address: _____

_____ Post code: _____

GP, Name and Surgery: _____

Surgery Address: _____

Person/s with
parental responsibility: _____

Diversity Needs

What is your first language? _____

Do you have any communication needs? _____

Do you have any spiritual or cultural needs that you would like to share with us?

_____

Medical History

How was the pregnancy? _____

_____

Were there any complications at birth? _____

_____

Was your baby born early? ☐ YES ☐ NO

Born at: _____ weeks Weight: _____

Current Medication: _____

_____

Investigations

Is your child undergoing any current investigations? For example: Awaiting MRI or orthotics?

_____:

_____

Past Medical History

Serious Illnesses? _____

Serious Injuries? _____

Has your child been diagnosed with a long-term condition? ☐ YES ☐ NO

If YES, please state the condition diagnoses and by whom and when was your child diagnosed

_____

Allergies/sensitive skin? _____

Seizures/fits? ☐ YES ☐ NO

If YES, are they ☐ Controlled ☐ Uncontrolled

Please give date of last seizure and treatment given:

_____

Do you have any reason why you may have to cancel therapy with less than 48 hours notice?

_____

Vision, Hearing and Communication

Has your child's hearing been tested recently? ☐ YES ☐ NO

Has your child's vision been tested recently? ☐ YES ☐ NO

Does your child have any reported visual or auditory problems? ☐ YES ☐ NO

If YES, please give details _____

Movement

At what age did your child:

Roll _____ Sit _____

Crawl _____ Stand _____

Cruise _____ Walk _____

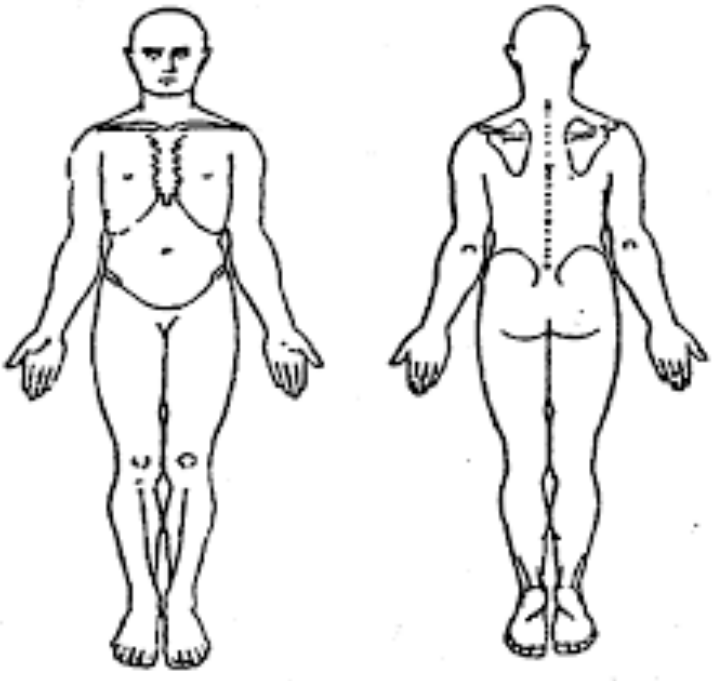
Does your child have a favoured hand? ☐ YES ☐ NO ☐ Right ☐ Left

Is your child able to keep up with their siblings or peers? ☐ YES ☐ NO

Does your child complain of pain? ☐ YES ☐ NO

If YES, please state when _____

If YES, please show where on the body



Outside of School

Does your child participate in any physical activities? (For example: football, swimming, cubs, scouts?)

_____

_____

Please list in order the concerns you would like to discuss with your therapist:

1. _____
2. _____
3. _____
4. _____
5. _____

Is there anything that you wish to discuss without your child present?

_____

_____

_____

_____

Signed: _____ Date: _____