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.

Some of it may not be relevant, so please only fill in the parts you need to. If you are unsure of any questions, please speak with one of our team who will be able to assist.

Thank you.

Kids' Therapy Works

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: ____

Kids' Therapy Works

Educational Needs

Does your child have a SEN? ☐ YES ☐ NO

Does your child have an IEP? ☐ YES ☐ NO

Does your child have any extra support in school? § ☐ YES ☐ NO

If YES, please detail: ____________________

Has your child been seen by any NHS professionals in school? ☐ YES ☐ NO
For example: Physiotherapists, Occupational Therapists, SLTs?

Profession: (eg. Physio, OT, SLT)	Name:	Last Seen (Date)

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?

____

Kids' Therapy Works

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 in their legs? ☐ YES ☐ NO

If YES, please state when ______________________________

Does your child fall over more often than expected? ☐ YES ☐ NO

Outside of School

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

____

____

Can your child ride a bike? ☐ YES ☐ NO

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: ________________