**Children’s Occupational Therapy**

INFORMATION GATHERING FORM – SCHOOL AGE CHILDREN

|  |  |  |  |
| --- | --- | --- | --- |
| **Child’s name:** |  | **Date of birth** |  |

(Child’s name) has been referred to the Children’s Occupational Therapy Service for assessment and advice. The information you give us in this questionnaire will help us to establish if we are the most appropriate service, and, if so, the type of assessment that may be offered. Please try to answer as many of the questions as you can. If you do have difficulty answering the questions or completing the form, please contact us on the number given.

Occupational Therapy (O.T.) looks at the occupations a child needs to do at home, school and play and the reasons why they may find these difficult. We divide these occupations into groups, which are:

* **Self-care** includes personal care, mealtimes, dressing and walking
* **Work** includes learning at home or school
* **Leisure** includes free play and play with other children

In order to be eligible for Occupational Therapy assessment, a child or young person must be demonstrating a cluster (2 or more) of functional difficulties in these areas of self-care, school work, accessing play and leisure that are impacting significantly on their daily life. Referrals for children and young people with generalised developmental delay will only be accepted if their physical and sensory functioning is significantly more delayed than their intellectual functioning. More information is available on our website: [www.devon.integratedchildrensservices.co.uk](http://www.devon.integratedchildrensservices.co.uk)

Please note that we do **NOT** provide O.T. services for:

* Children and young people who present with **primary emotional and behavioural difficulties** not related to any underlying motor dysfunction
* Children and young people requiring assessment for **Dyslexia**
* When a housing need is as a result of **overcrowding** not disability

|  |  |
| --- | --- |
| **Person completing form and Relationship to child** |  |
| Contact telephone no: |  |
| School attending: |  |

**Parents/carers – please complete the questions on these pages**

**Family history:**

|  |  |
| --- | --- |
| **Please tell us who is at home and who cares for your child** |  |
| **Mother’s name** |  |
| Address (if different from your child’s) |  |
| **Father’s name** |  |
| Address (if different from your child’s) |  |
| Brothers and/or sisters (including ages) |  |

**Birth history:**

# Please tell us about your pregnancy and your child’s start in life.

**1.** Were there any complications during the pregnancy or at the birth of your child? *(Please describe)*

|  |
| --- |
|  |

**2.** Was your child born at term or premature?  *(number of weeks)*

|  |
| --- |
|  |

**3.** Birth weight and length

|  |
| --- |
|  |

**4.** Did your child require any special care or treatment after birth?

|  |
| --- |
|  |

**Early development history:**

|  |  |
| --- | --- |
| **1.** Did your child breast or bottle-feed and were there any difficulties? |  |
| **2.** When did your child first smile? |  |
| **3.** When did your child first sit up on their own? |  |
| **4.** When did your child first stand on their own? |  |
| **5.** When did your child take their first step? |  |
| **6.** When did your child say their first words? |  |
| **7.** When did you introduce your child to solid food and were there  any difficulties? |  |
| **8.** Was your child happy to lie on his/her tummy? |  |
| **9.** Did your child crawl or bottom shuffle? |  |
| **10.** Was your child a good sleeper or were there any problems? |  |
| **11.** Did your child ‘mouth’ on their toys, etc? |  |
| **12.** At what age was your child toilet trained? |  |

**13.** Which of these words would describe your child as an infant: (tick as appropriate)

|  |  |  |  |
| --- | --- | --- | --- |
|  | Alert |  | Quiet |
|  | Good sleep patterns |  | Irregular sleep patterns |
|  | Cried at first/fussy/irritable |  | Non-demanding |
|  | Liked being held |  | Resisted being held |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Medical and health history:** | **Yes** | | | **No** | | |
| **1.** Does your child have a diagnosis to describe some of their difficulties? |  |  |  |  |  |  |
| *If so, what?* | | | | | |  |
|  | | | | | |  |
| **2.** Does your child wear glasses or have any visual problems |  |  |  |  |  |  |
| **3.** Does your child have hearing difficulties or has suffered with lots of ear infections? |  |  |  |  |  |  |
| **4.** Has your child had any significant childhood illnesses? *If so, what?* |  |  |  |  |  |  |
|  | | | | | |  |
| **5.** Is your child on any medication? *If so, what?* |  |  |  |  |  |  |
|  | | | | | |  |
| **6.** Has your child had any surgery or tests carried out and if so, what? |  |  |  |  |  |  |
|  | | | | | |  |
| **7.** Is your child being seen by a Paediatrician; and if so whom? |  |  |  |  |  |  |
|  | | | | | |  |

**School staff – please complete the questions on this page**

**Educational history:**

**1.** When did it first become apparent that this child was having difficulties?

|  |
| --- |
|  |

**2.** What was your action to address this in school?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | | | | | |
|  | | **Yes** | | | **No** | | | |
| **3.** Have you applied for additional funding to support this child in school? | |  |  |  |  |  | |

**4.** What other professionals have been involved or are involved with this child?

|  |
| --- |
|  |

**5.** What is the level of additional support given to this child and how is it delivered?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | | | | | |
| **6.** Has this child got an Education Health and Care Plan? |  |  |  |  |  | |
| **7.** Have you noticed any visual difficulties? *If so, what?* |  |  |  |  |  | |
|  | | | | | | |
| 1. Does this child wear spectacles? |  |  |  |  |  | |
| **8.** Have you noticed any hearing difficulties? *If so, what?* |  |  |  |  |  | |
|  | | | | | | |
| 1. Does this child wear hearing aids? |  |  |  |  |  | |
| **9.** Does this child have any communication difficulties and how is this supported? |  |  |  |  |  | |
|  | | | | | | |
| **10.** Does this child take any medication at school? |  |  |  |  |  | |
|  | | | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **School occupations:** | **Not learnt to do as yet** | **Is learning to do with some help** | **Enjoys and does independently** |
| Reading and literacy |  |  |  |
| Writing and recording |  |  |  |
| Drawing |  |  |  |
| Design and technology |  |  |  |
| Spelling |  |  |  |
| Mathematics |  |  |  |
| Information technology |  |  |  |
| PE games |  |  |  |

**Parents/carers *and* school staff – please complete the remaining questions**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Self care skills:** | **Unable to do** | **Can do with difficulty** | **Can do well** | **Comments** |
| Dressing/  undressing (including for PE) |  |  |  |  |
| Zips and buttons |  |  |  |  |
| Shoelaces |  |  |  |  |
| Putting clothes on in the right order |  |  |  |  |
| Putting clothes on the right way round |  |  |  |  |
| Using a knife and fork for mealtimes |  |  |  |  |
| Drinking from a cup |  |  |  |  |
| Pouring a drink |  |  |  |  |
| Opening lids/crisp packets/yoghurt pots |  |  |  |  |
| Sucking through a straw |  |  |  |  |
| Brushing hair |  |  |  |  |
| Brushing teeth |  |  |  |  |
| Washing hands, face and body |  |  |  |  |
| Drying self |  |  |  |  |
| Using the toilet and cleaning self |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Movement:** | **Unable to do** | **Can do with difficulty** | **Can do well** | **Comments** |
| Walking |  |  |  |  |
| Running |  |  |  |  |
| Jumping |  |  |  |  |
| Hopping |  |  |  |  |
| Balancing |  |  |  |  |
|  | **Unable to do** | **Can do with difficulty** | **Can do well** | **Comments** |
| Riding a bicycle |  |  |  |  |
| Throwing a ball |  |  |  |  |
| Catching a ball |  |  |  |  |
| Climbing |  |  |  |  |
| Judging speed and force |  |  |  |  |
| Swimming |  |  |  |  |
| Drawing and writing |  |  |  |  |
| Using a mouse and keyboard |  |  |  |  |
| Using scissors |  |  |  |  |
| Construction activities |  |  |  |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Sensation:** | **Likes a lot** | **Likes** | **Dislikes** | **Dislikes a lot** | **Don’t know** | **Comments** |
| Being tickled |  |  |  |  |  |  |
| Being hugged |  |  |  |  |  |  |
| Woolly jumpers |  |  |  |  |  |  |
| Walking barefoot |  |  |  |  |  |  |
| Strong tastes |  |  |  |  |  |  |
| Strong smells |  |  |  |  |  |  |
| Being ‘dirty’ |  |  |  |  |  |  |
| Having hair washed |  |  |  |  |  |  |
| Having hair brushed |  |  |  |  |  |  |
| Brushing teeth |  |  |  |  |  |  |
| Being dried with a towel |  |  |  |  |  |  |
| Playground swings/roundabouts |  |  |  |  |  |  |
| Car journeys |  |  |  |  |  |  |
| Rough and tumble play |  |  |  |  |  |  |
| Heights |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | **Yes** | | | **No** | | | |
| **1.** Are there any sensations, textures or activities the child appears to avoid? | |  |  |  |  |  | |
|  | | | | | |
|  | | **Yes** | | | **No** | | | |
| **2.** Does the child tire easily? | |  |  |  |  |  | |
| **3.** Does the child easily become irritable? | |  |  |  |  |  | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Behaviour:** | **Yes** | | | **No** | | |
| **1.** Can the child listen to and follow instructions? |  |  |  |  |  |
| **2.** Can the child organize themselves and their belongings? |  |  |  |  |  |
| **3.** Does the child cope with changes in routine? |  |  |  |  |  |
| **4.** Does the child make friends easily? |  |  |  |  |  |
| **5.** Have you any concerns about the child’s behaviour? |  |  |  |  |  |
|  | | | | | |

**Play and leisure skills:**

|  |  |
| --- | --- |
| **1.** Does the child prefer indoor or outdoor activity? |  |
| **2.** What are the child’s favourite toys, games or activities? |  |
| **3.** Does the child prefer to play alone or with other children or adults? |  |
| **4.** Does the child prefer to play with older or younger children? |  |
| **5.** Does the child belong to any in-school, after-school or weekend clubs? *Give details* | |
|  | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Parents/Guardian’s Consents:** | **Yes** | | | **No** | | |
| **1.** Do we have your permission to take photographs / video recordings of your child for evaluation and student training purposes? |  |  |  |  |  |
|  |  |  |  |  |
| **2.** May we obtain reports from your child’s doctor / other agencies in order to monitor your child’s progress? |  |  |  |  |  |
|  |  |  |  |  |

**General information:**

**1.** What are your main concerns regarding the child at present?

|  |
| --- |
|  |

**2.** How would you describe the child’s strengths?

|  |
| --- |
|  |

**3.** What help are you hoping to receive from Occupational Therapy?

|  |
| --- |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Signed:** |  | **Date:** |  |

Thank you for taking the time to complete this. Please return the questionnaire and consent form as soon as possible to the Integrated Children’s Services Single Point of Access in the enclosed envelope. If you want to speak to a member of staff about completing this questionnaire please ring **0330 024 5321**.