OCCUPATIONAL THERAPY PARENT QUESTIONNAIRE

PERSONAL DETAILS

Child's name:		**Parent's name:**	

GROSS MOTOR SKILLS

Does your child:

Like to play outside?	☐ Yes, ☐ No	**Details:**	
Ride a bike without training wheels?	☐ Yes, ☐ No	**Details:**	Any concerns? A: _____
Experience difficulty catching balls?	☐ Yes, ☐ No	**Details:**	
Appear clumsy or uncoordinated?	☐ Yes, ☐ No	**Details:**	
Appear awkward when running, hopping, or skipping?	☐ Yes, ☐ No	**Details:**	
Swim?	☐ Yes, ☐ No	**Details:**	
Enjoy swimming?	☐ Yes, ☐ No	**Details:**	
Play a sport?	☐ Yes, ☐ No	**Details:**	

FINE MOTOR SKILLS

Does your child:

Hold their pencil correctly?	☐ Yes, ☐ No	**Details:**	
Enjoy colouring or drawing activities?	☐ Yes, ☐ No	**Details:**	
Demonstrate hand preference (i.e. left or right handed)?	☐ Yes, ☐ No	**Details:**	
Use scissors correctly?	☐ Yes, ☐ No	**Details:**	
Have difficulty manipulating small objects in their hands (e.g. beads, buttons, counters)?	☐ Yes, ☐ No	**Details:**	

COGNITIVE SKILLS

Does your child:

Follow instructions	☐ Yes, ☐ No	**Details:**	☐ 1 step, ☐ 2 steps, ☐ 3 steps, ☐ > 3 steps
Appear to forget information easily?	☐ Yes, ☐ No	**Details:**	
Appear to have difficulty with planning and sequencing tasks?	☐ Yes, ☐ No	**Details:**	
Get easily distracted?	☐ Yes, ☐ No	**Details:**	

SOCIAL/EMOTIONAL SKILLS – which of the following apply?

☐ Temper tantrums, ☐ Easily frustrated, ☐ Impulsive, ☐ Dislikes change, ☐ Perfectionist, ☐ Separation difficulties, ☐ Anxious, ☐ Sensitive, ☐ Quiet, ☐ Difficulty sharing/taking turns, ☐ Difficulties being flexible with rules, ☐ Overly affectionate, ☐ Difficulty making friends, ☐ Difficulty making eye contact, ☐ Socially immature, ☐ Prefers to play alone, ☐ Difficulties understanding other's emotions.

SELF-CARE SKILLS – which of the following apply?

Can your child?

Toilet independently?	☐ Yes, ☐ No	**Details:**	
Dress themselves?	☐ Yes, ☐ No	**Details:**	
Do up buttons and zips independently?	☐ Yes, ☐ No	**Details:**	

Tie their shoelaces independently?	☐ Yes, ☐ No	**Details:**		
Use cutlery at meal time?	☐ Yes, ☐ No	**Can use:**	☐ Knife, ☐ Fork, ☐ Spoon	Comment: _____
Ever wet the bed at night?	☐ Yes, ☐ No	**Details:**		

Sleep well? ☐ Yes, ☐ No Any specific concerns?: _____	**Details:**	☐ Falls asleep and stays asleep, ☐ Self-soothes if wakes, ☐ Sleeps with light on, ☐ Sleeps in room independently, ☐ Shares room with someone, ☐ Takes medications or uses equipment (e.g. weighted blanket) to help sleep.		
	Medication (if any)		**Equipment (if any)**	

VISUAL PERCEPTUAL SKILLS

Does your child:

Reverse letters or numbers when reading/writing?	☐ Yes, ☐ No, ☐ N/A	**Details:**	
Experience difficulty completing puzzles or mazes?	☐ Yes, ☐ No	**Details:**	
Experience difficulty finding things in their room/cupboard/drawer, etc.?	☐ Yes, ☐ No	**Details:**	
Frequently lose their place when reading	☐ Yes, ☐ No, ☐ N/A	**Details:**	

SENSORY PROCESSING SKILLS

Select which best describes your child:

Bumps into things/poor balance	☐ **Frequently,** ☐ **Sometimes,** ☐ **Never**	**Comments:**	
Crashes to the floor	☐ **Frequently,** ☐ **Sometimes,** ☐ **Never**	**Comments:**	
Constantly moving	☐ **Frequently,** ☐ **Sometimes,** ☐ **Never**	**Comments:**	
Likes to swing excessively	☐ **Frequently,** ☐ **Sometimes,** ☐ **Never**	**Comments:**	
Dislikes climbing on playground equipment	☐ **Frequently,** ☐ **Sometimes,** ☐ **Never**	**Comments:**	
Seems oblivious to pain	☐ **Frequently,** ☐ **Sometimes,** ☐ **Never**	**Comments:**	
Avoids messy play	☐ **Frequently,** ☐ **Sometimes,** ☐ **Never**	**Comments:**	
Avoids eye contact	☐ **Frequently,** ☐ **Sometimes,** ☐ **Never**	**Comments:**	
Covers ears with loud noises	☐ **Frequently,** ☐ **Sometimes,** ☐ **Never**	**Comments:**	
Fussy or picky eater	☐ **Frequently,** ☐ **Sometimes,** ☐ **Never**	**Comments:**	
Dislikes having hair washed or cut	☐ **Frequently,** ☐ **Sometimes,** ☐ **Never**	**Comments:**	
Chews on non-food items	☐ **Frequently,** ☐ **Sometimes,** ☐ **Never**	**Comments:**	

ADDITIONAL INFORMATION

Your child's favourite outdoor activities:		
Your child's favourite indoor activities:		
Your child's distinct fears (if any):		
Do these fears interfere with everyday functioning?	☐ Yes, ☐ No, ☐ Sometimes.	Details: _____

Do you have any further comments/concerns/goals/questions in regards to your child or the information requested?

Would you like me to contact you directly to discuss the information provided here or anything else? ☐ Yes ☐ No

If yes, please let me know the time(s) and day(s) that would work best for you:

Day(s):	☐ **Mon,** ☐ **Tues,** ☐ **Wed,** ☐ **Thur,** ☐ **Fri**	**Time(s):**	