THE SKIDMORE CLINIC
Occupational Therapy

Parent Questionnaire/Screening Form:

Child's Name: _____

Date of Birth: _____Age:_____Gender: Male Female

Parent/Caregiver name: _____

Telephone:_____Email:_____

GP: _____

Does your child have a diagnosis? If yes, what is the diagnosis and who made it?

Medication (if any): _____

School/ Childcare:_____ Class: _____

Do the school have any concerns relating to your child's physical or sensory processing skills or have they raised any specific concerns in relation to play, handwriting, organisation or attention/learning etc.

REASON FOR SEEKING OCCUPATIONAL THERAPY

What are your child's strengths and areas of difficulty?

Has your child ever been referred to the HSE Early Intervention Forum : Yes/No

If yes has a service been assigned and if so which one?

- North Lee ASD (Bridgeway)
- HSE Early Intervention Team
- Cope Early Intervention Team
- Enable Ireland
- CAMHS
- Community OT
- Not sure

Is your child

- Currently receiving services
- On a waiting list
- Nor sure
- None of the above

Do you have any concerns about your child's hearing? Yes / No

Details:

Do you have any concerns about your child's vision? Yes/ No

Details:

DEVELOPMENTAL HISTORY

At what age (roughly) did your child achieve the following milestones?

Hold head up:	Crawl/Bottom Shuffle (state which)
Sit independently	Stand alone:
Roll over	Walk independently

ACTIVITIES OF DAILY LIVING

Please tick any difficulties your child experiences:

Using scissors	Jumping
Playing with small toys	Learning new motor skills
Completing puzzles	Riding a bike
Using cutlery	Doing shoelaces
Tying shoe laces	Holding a pencil
Catching a ball	Writing / drawing
Kicking a ball	Dressing
Sleeping	Playing

SOCIAL EMOTIONAL SKILLS Please tick any difficulties your child experiences:

Mostly quiet	Overly active	Tires easily	Impulsive
Restless	Stubborn	Resistant to change	Sensitive
Talks constantly	Fights frequently	Temper tantrums	Wets bed
Separation difficulties	Immature	Overly affectionate	Anxious
Fearful	Frustrated easily	Poor attention	Perfectionist

SENSORY PROCESSING Please tick the response that best describes your child's behaviour. Add any additional comments where appropriate.

	Frequently	Sometimes	Never	Comments
Is in constant motion/unable to sit still for an activity				
Has trouble concentrating				
Seems to always be running, jumping, or stomping				
Bumps into things or frequently knocks things over				
Reacts strongly to being bumped or touched				
Avoids messy play and doesn't like to get hands dirty				
Hates having hair washed, brushed or cut				
Resists wearing new clothing or is bothered by tags or socks				
Distressed by loud or sudden sounds				
Hesitates to play or climb on playground equipment				
Difficulties with balance				
Loses place when reading or copying from board				
Difficulties tracking objects with eyes				
Mood variations, outbursts and tantrums				
Avoids eye contact				
Has trouble following multistep instructions				
Fussy eater, often gags on food				
Reacts strongly to smells				
Has a high pain threshold				

Please return to: theskidmoreclinic@gmail.com or

The Skidmore Clinic, Unit 2, First Floor, Carrigtwohill Shopping & Business Centre, Main Street, Carrigtwohill, Co. Cork