

Barnet Children & Young People’s Occupational Therapy

Edgware Community Hospital

3rd Floor, Westgate House

Burnt Oak Broadway

Edgware, HA8 0AD

Phone 0203 316 8900

# Children & Young People’s Therapy

**Pre-School Parent Questionnaire**

Your child has been referred to the Barnet children’s Therapy service. Therapy can provide assessment, strategies and advice to help address difficulties a child may be experiencing in the occupational areas of movement, play/leisure, self-care/ independence skill development and nursery/school life.

It would be helpful to us to know more about your current concerns regarding your child’s functional abilities and difficulties. This will help us to determine if we can offer your child the appropriate service and where offered, to make our assessment more accurate. Your comments can indicate your priorities for any input that may be offered.

Some sections or questions may not be relevant due to your child’s age/developmental abilities but please try to fill in the form as comprehensively as possible. This will allow us to make a prompt decision regarding your child’s current functional needs.

We will contact you and the referrer after we receive the completed questionnaire.

PLEASE RETURN THIS FORM WITHIN **10 WORKING DAYS** TO THE ADDRESS BELOW, OTHERWISE WE WILL ASSUME YOU NO LONGER REQUIRE OUR SERVICE

**Please return this with the referral form to:**

Occupational Therapy and Physiotherapy Referrals

Edgware Community Hospital

3rd Floor, Westgate House

Burnt Oak Broadway

Edgware, HA8 0AD

Or email the questionnaire to: whh-tr.barnetCIT@nhs.net

If you have any questions please do not hesitate to contact us on 0203 316 8900

Regards,

The Children & Young People’s Occupational Therapy and Physiotherapy Team

|  |  |
| --- | --- |
| ***Surname:***  | Child Development Service involved: Y / N Special needs register: Y / N  |
| ***First name:*** ***Gender :***  | **Date of birth:**  |
| Nickname: | NHS number:  |
| Parent/Carer Name(s): | Nationality: Ethnicity:  |
|  | Language Spoken:  |
| Address:  | Interpreter Needed: **Y / N** |
|  | Religion:  |
|  | Home Situation: |
| Postcode:  | Second Address: |
| Borough: |  |
|  | GP Details:  |
| Home Phone:  |  |
| Mobile Phone:  |  |
| Work Phone:  | **School/Nursery:**  |
| Email Address:  |  |
|  |  |
| Presenting Condition/ Diagnosis: | SENCO: |
|  | Teacher: |
|  |  |
| Childs academic abilities  | Statemented/ EHC Y / N Date:Details of EHC provision for OT |

**Other involved professionals**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***Name:*** | ***Profession:*** | ***Address:*** | ***Phone:*** | ***Date of involvement:*** |
|  |  |  |  |  |
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**Background information:**

Is your child currently under medical treatment or has your child been treated for any major illnesses? (Please state illness)

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What are your major current concerns about your child?

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What activities would you like your child to do better?

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Developmental History**:

Birth History: (please circle)

Complicated / Normal / Premature

If premature, how early was your child born? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Developmental Milestones: (please indicate the months)

Rolling: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sitting: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Crawling: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Walking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Talking (first words): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EARLY DEVELOPMENTAL MOTOR SKILLS**

Please ✓ and comment on your childs’ ability in the following area:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Posture & Movement** | **Yes** | **With Difficulty** | **No** | **Age child achieved it/ Comments** |
| Get up off the floor independently  |  |  |  |  |
| Run  |  |  |  |  |
| Jump |  |  |  |  |
| Hop (either foot) |  |  |  |  |
| Throw/catch a ball |  |  |  |  |
| Climb Stairs  |  |  |  |  |

How far can your child move around the home? / playgroup?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How does your child negotiate steps/stairs? Upstairs:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Downstairs:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How does your child move around when outside? (including on rough ground)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **SELF-CARE SKILLS/INDEPENDENCE**What are the difficulties your child has in engaging in self-care tasks | **COMMENTS** |
| Dressing :E.g. Describe ability to get dressed, does your child need help/independent, require help with buttons/zips/shoelaces, able to identify top, bottom, back, front of clothes |  |
| EatingDescribe your child’s ability to feed him/her self. For example: without help, uses spoon and fork, uses fingers, messy eaterAble to hold the plate/bowl etc. |  |
| ToiletingDescribe his/her ability to use the toilet.For example: Potty trained, day/night still in nappies, get on and off toilet/potty. |  |
| **PLAY/LEISURE**:Describe the difficulties your child experiences when engaging in play/leisure activities |  |
| PlayDescribe how your child plays. Alone or alongside peers. What is your child’s favourite games/toys? Are there any play tasks they struggle to play with/manipulate in their hands, or any help needed to engage in play? |  |
| **PARTICIPATION IN NURSERY/SCHOOL LIFE**Describe what difficulties are experienced in their play-group/nursery/school life |  |
| E.g. Any difficulty accessing the environment, manipulating and organising tools (scissors, glue sticks, pencils), working independently, managing self-care routines in school life |  |
| **COMMUNICATION**Describe how your child communicates |  |
| E.g. verbal /non-verbal/use of signs/symbols, gestures, interaction with others |  |
| Any other comments, which you feel will help us identify whether Occupational Therapy can help your child. |  |

Thank you for taking the time to fill in this questionnaire. All information supplied is confidential.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Whittington Health NHS Trust



Chair: Baroness Julia Neuberger Chief Executive: Helen Brown



**Helping local people live longer healthier lives**