# Parental / Carer Questionnaire

In order to maximise your practical assessment time in clinic we would be grateful if you would take the time to fill out the following questionnaire.

Some of it may not be relevant to your child so please only fill out the parts you need to. If you are unsure about any of the questions then please speak to one of our team who will be able to assist.

Many thanks

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| BASIC INFORMATION | | | |
|---|---|---|---|
| **First Name** | **Surname** | **Likes to be called** | **DOB** |
| | | | |
| Home Address: | | | |
| Email Address : | | | |
| Home Telephone Number: | | | |
| Mobile Telephone Number: | | | |
| Mothers Name: | | | |
| Fathers Name: | | | |
| Carers Name: | | | |
| Siblings Names & Ages: | | | |
| School Name & Address: | | | |
| GP Name & Surgery Address: | | | |
| Person/s with Parental Responsibility: | | | |
| **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? For example: Physiotherapists, Occupational Therapists? (Please name below) | | | |

| **Professional** | **Name** | **Last Seen** |
|---|---|---|
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| **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? | | |
| **MEDICAL HISTORY** | | |
| How was the pregnancy? | | |
| Were there any complications at birth? | | |
| Was your baby born early? | Born at: | 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/Senstive Skin? | |
| Seizures/fits?<br>If **YES** are they controlled or uncontrolled? | |
| Please give date of last seizure and treatment given: | |
| **Do you have any reason why you may have to cancel your physio in under 48 hours notice?** | |
| **VISION, HEARING & 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 detail: | |

| | |
|---|---|
| Does your child have any additional communication needs? | YES/ NO |
| If **YES** please give detail: | |
| **MOVEMENT** | |
| At what age did your child...? | |
| Roll: | |
| Sit: | |
| Crawl: | |
| Stand: | |
| Cruise: | |
| Walk: | |
| Does your child have a favoured hand? | YES/ NO<br><br>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?<br><br>(For example: football, swimming, cubs, scouts?) | |

| | | |
|---|---|---|
| Can your child ride a bike? | YES/ NO | |
| Please list in order your concerns you would like to discuss with your Physiotherapist: | 1. | |
| | 2. | |
| | 3. | |
| | 4. | |
| | 5. | |
| Is there anything that you wish to discuss without your child present? | | |