Insight Coordination

PARENT QUESTIONNAIRE / INTAKE ASSESSMENT FORM

PERSONAL DETAILS

Child's Full Name:					
Date of Birth:		**Age:**		**Gender:**	☐ Male ☐ Female
Caregiver:				**Contact details:**	
General Practitioner:				**Contact details:**	
Paediatrician:				**Contact details:**	

SOCIAL HISTORY

In order for us to best work with you, we need to know a little about your family, please answer the questions below. If you are unsure how to answer, feel free to leave those sections for our first session.

Are there any formal custody arrangements in place?	☐ Yes ☐ No
If YES, please give details:	

Please provide details of your family: (name, gender, age, half/step siblings)

Please provide details of any relevant family medical history: (autism, learning problems, mental health problems)

Please provide details of any family history which might impact on your child: (divorce, separation, recent moves)

ABOUT YOUR CHILD

Favourite toys or activities:
Favourite movie or TV characters:
Favourite movie or TV shows:
Does your child like active/physical play or quiet/sit down play?
Does your child prefer playing in large groups or with 1-2 children?
Does your child enjoy imaginary play? If so, what does he/she like to play?
What do you see as your child's strengths?
In one sentence, how would you describe your child?
Do you have any additional information that will help to better understand your child?

SCHOOL HISTORY

School Name:					
Grade:		**Hand Preference**	Right ☐ Left ☐	**Have any grades been repeated?**	Yes ☐ No ☐
Is your child in a special class (specify)?					
What does the teacher say about your child?					

REASON FOR SEEKING SUPPORT COORDINATION

What are your main concerns regarding your child?

What do you want to achieve for your child by coming to Insight Coordination?

Who referred you to Insight Coordination?

TREATMENT HISTORY

Please indicate if your child has received therapy before.

Discipline	**Name & Location**	**Current Goals**	**Frequency**
Paediatrician			
Psychologist			
Speech Pathologist			
Occupational Therapy			
Physiotherapy			
Dietician / Nutritionist			
Other			

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BRIEF HISTORY

Did you have any problems during pregnancy?		☐ Yes ☐ No	
If YES, please give details:			
Was the birth?	☐ Premature ☐ Full Term ☐ Overdue	**Weeks:**	
Type of delivery:	☐ Normal ☐ Caesarean ☐ Breech ☐ Other	**Details:**	
Length of labour:	☐ Normal ☐ Prolonged	**Details:**	
Did the baby require?	☐ Oxygen ☐ Tube Fed ☐ Transfusions ☐ NICU/Special Care Nursery		
Details and duration:			
Was your child?	☐ Breast Fed ☐ Bottle Fed ☐ Both	**How long?**	

MEDICAL HISTORY

Diagnosis:			
Medication:			
How often does your child get sick?	☐ Frequently ☐ Occasionally ☐ Rarely		
Does your child have any allergies?	☐ Yes ☐ No	**Details:**	

Has your child experienced any of the following?	
☐ Snoring / mouth breathing?	☐ Bad breath
☐ Ear infections	☐ Hyperactivity
☐ Head injury	☐ Sleep challenges
☐ Fractured limbs	☐ Family history allergies
☐ Frequent daydreaming	☐ Eczema / skin rashes
☐ Reflux	☐ Dark circle (purple shiners) under eyes
☐ Constipation / diarrhoea	☐ Asthma / respiration problems
☐ Bloating / gas / tummy discomfort	☐ Other

Has your child's hearing been tested?	☐ Yes ☐ No	**Details:**	
Has your child's vision been tested?	☐ Yes ☐ No	**Details:**	

Please list any surgeries or procedures our child has undergone with approximate date:

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DIETARY HISTORY

Do you have concerns with any of the following?		
☐ Mealtime behaviours	**Details:**	
☐ Dietary variety	**Details:**	
☐ Dietary quality	**Details:**	
☐ Response to new foods	**Details:**	

DEVELOPMENTAL HISTORY

At what age did your child achieve the following milestones?					
Hold head up:		Sit independently:		Roll over:	
Creep:		Crawl:		Stand alone:	
Walk independently:		First word:		Point:	
Wave:		Hand preference:			

VISUAL & MOTOR SKILLS

Please tick any difficulties your child experiences:	
☐ Using scissors	☐ Jumping
☐ Playing with small toys	☐ Using cutlery
☐ Completing puzzles	☐ Doing shoelaces
☐ Learning to swim	☐ Holding a pencil
☐ Riding a bike	☐ Writing / drawing
☐ Catching a ball	☐ Pumping self on swing
☐ Kicking a ball	☐ Learning new motor skills

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
☐ Fearful	☐ Frustrated easily	☐ Poor attention	☐ Perfectionist
☐ Separation difficulties	☐ Immature	☐ Overly affectionate	☐ Anxious

Please list any other social emotional difficulties your child experiences:

SOCIAL HISTORY

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

Situation/ Behaviour	Frequently	Sometimes	Never	Comments
Seems to be in constant motion or is unable to sit still for an activity	☐	☐	☐	
Has trouble concentrating or can't stay on task	☐	☐	☐	
Seems to always be running, jumping, or stomping rather than walking	☐	☐	☐	
Bumps into thing or frequently knocks things over	☐	☐	☐	
Reacts strongly to being bumping 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 such as a siren or a vacuum	☐	☐	☐	
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 good	☐	☐	☐	
Reacts strongly to smells	☐	☐	☐	
High pain threshold	☐	☐	☐	

TYPICAL DAY: PLEASE DESCRIBE A TYPICAL WEEKDAY AND WEEKEND FOR YOUR CHILD AND FAMILY

Weekday:	
Weekend:	