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| **PLEASE ATTACH ALL PREVIOUS ASSESSMENT REPORTS** |
| Date of submission |       | Date of completion |       |
| Please think carefully about your child’s development and describe behaviours that are brought to mind when you answer these questions:* Were these different from other children you know?
* Were there occasions when these behaviours made if difficult to cope as a family?
* Did you find solutions which helped to deal with any problem behaviours?

The questions are designed to assist in formulating a picture of your child and his/her development. Take time to think about the questions. Some may not apply to your child, but if they do, please answer as fully as possible. |
| **Details of Applicant/Child to be assessed (kindly submit a photo of your child)** |
| **Personal** |
| **Surname**  |       |
| **Full first name**  |       |
| **Date of birth**  |       | **ID Number** |       |
| **Age**  |       | **Gender** |       |
| **Home language**  |       |
| **Religion**  |       |
| **Present medication and dosage** |       |
| **Street address** |       |
| **Postal address** |  |
| **Why are you seeking assessment for your child?**      |

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| **Medical Aid Details** |
| **Medical aid and contact no.** |       |
| **Membership number** |       |
| **Medical aid package**  |       |
| **Dependant code**  |       |

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| **School History** |
| **Current School** |
| **Name of school**  |       |
| **School’s telephone number**  |       |
| **Principal name** |       |
| **Class teacher**  |       |
| **Teacher’s telephone number** |       |
| **Teacher’s email address**  |       |
| **Present grade** |       |
| **Grade’s repeated** |       |
| **Medium of instruction eg Eng/Afr/other**  |       |
| **Do you give us permission to contact your current school** |       |
| **Schools Attended** |
| **Facility** | **Name** | **Month & Year of entry** | **Child’s Age** | **Month and Year of exit** |
| **Crèche** |       |       |       |       |
| **Nursery School** |       |       |       |       |
| **Primary School** |       |       |       |       |
| **High School** |       |       |       |       |
|  |
| **Was your child considered ready for Primary School?** |
| **Was your child considered ready for Primary School** | Yes | [ ]  | No | [ ]  |
| **Was a Readiness Assessment conducted?** | Yes | [ ]  | No | [ ]  |
| **If your child was considered not ready, what reasons were given?**  |
|       |
| **In which grade were the difficulties first noticed?** |
|       |
| **Comment on the school your child is presently attending. How many children are there in his/her class? Does your child relate well to his/her teacher? Are you happy with the attention he receives?** |
|       |

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| **Parental Information** |
| **Father** |
| **Title** |      |
| **Full name**  |       |
| **ID Number** |       |
| **Present occupation**  |       |
| **Nationality**  |       |
| **Name of business**  |       |
| **Business address**  |       |
| **Business telephone number**  |       |
| **Cell phone number**  |       |
| **Home telephone number**  |       |
| **Email Address**  |       |
| **Residential Address**  |       |
| **Postal Address** |       |
| **Previous occupations over child’s lifespan**  |       |
| **Have any of these jobs necessitated long absences from home** |       |
| **Mother** |
| **Title** |       |
| **Full name**  |       |
| **ID Number**  |       |
| **Present occupation**  |       |
| **Nationality**  |       |
| **Name of business**  |       |
| **Business address**  |       |
| **Business telephone number**  |       |
| **Cell phone number**  |       |
| **Home telephone number**  |       |
| **Email Address** |       |
| **Residential Address**  |       |
| **Postal Address** |       |
| **Previous occupations over child’s lifespan**  |       |
| **Have any of these jobs necessitated long absences from home** |       |

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| **Marital Status** |
| Single | Married | Divorced | Separated | Widowed | Deceased |
| [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **If separated, to whom must documentation be sent?** | Both | [ ]  | Father Only | [ ]  | Mother Only | [ ]  |
| **If divorced, who has legal custody?** | Father | [ ]  | Mother | [ ]  |
| **If divorced does the other parent have access and visiting rights** | Yes | [ ]  | No | [ ]  |
| **Is this child:** | Biological | [ ]  | Fostered | [ ]  | Adopted | [ ]  |

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| **Siblings (In Chronological Age)** |
| **Name** | **Age** | **School** | **Class** | **Academic progress** |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
| **Position of child to be assessed, within the family:**  |       |
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| **How do you “see” your child?** |
| It is very important that each parent fill in this section separately as it contains valuable information.*This is not the place to discuss your present concerns (see page 8). Just describe your child as he/she appears to you.* |
| **Father’s Description** |
|       |
| **Mother’s Description** |
|       |
| **Other significant person’s description (AuPair etc)** |
|       |

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| **Your child now – at home** |
| (Please select [x]  the correct answer) |
| **Sleep** |
| Restless | [ ]  | Regular | [ ]  | Nightmares | [ ]  | Bedwetting | [ ]  | Sleepwalking | [ ]  |
| **Eating** |
| Good appetite | [ ]  | Fussy eater | [ ]  |
| **Habits** |
| Thumb sucking  | [ ]  | Nail biting  | [ ]  | Twitching  | [ ]  | Other  |       |
| **Can your child concentrate for an extended period of time, eg, playing, watching TV?** | Yes | [ ]  | No | [ ]  |
| **Do you have to continually repeat instructions?** | Yes | [ ]  | No | [ ]  |
| **Does your child get distracted easily?** | Yes | [ ]  | No | [ ]  |
| **How do you rate the following?**  |
| **Concentration** | Good | [ ]  | Average  | [ ]  | Poor | [ ]  |
| **Activity level** | Overactive | [ ]  | Normal | [ ]  | Poor | [ ]  |
| **Talks** | Too much | [ ]  | Average | [ ]  | Too Little | [ ]  |
| **Fidgets** | A lot | [ ]  | A little | [ ]  | Not at all | [ ]  |
| **Socially: (at home)** |
| **Does he/she prefer to play alone?** | Yes | [ ]  | No | [ ]  |
| **Does he/she like to have the company of friends?** | Yes | [ ]  | No | [ ]  |
| **Does he/she interact well with friends?** | Yes | [ ]  | No | [ ]  |
| **What age group does he/she prefer to play with?** | Older | [ ]  | Younger | [ ]  | Both | [ ]  |
| **How does he/she interact with family members?** |
|       |
| **How does he/she interact with other adults?** |
|       |
| **Present Concerns** |
| **Please state person and/or organisation who made the referral (eg. school, doctor, teacher, family friend or other)** |
|       |
| **Please state your reasons for seeking help** |
|       |
| **Please give details of your concerns. What do you think are the reasons for these problems and what are the contributing factors?** |
|       |

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| **Parent’s Education** |
| **Father** |
| **Primary Education** |       |
| **High School** |       |
| **Tertiary Education**  |       |
| **Mother** |
| **Primary Education** |       |
| **High School** |       |
| **Tertiary Education**  |       |
| **Family History** |
| **Comment on any factors you feel are significant within the family eg. physical and health or learning difficulties. Please elaborate where possible.** |
|       |
| **Did either parent experience concentration difficulties as a child?** |
| Father | Yes | [ ]  | No | [ ]  | Mother | Yes | [ ]  | No | [ ]  |
|       |       |
| **Now, as an adult, do you find it difficult to sustain attention?** |
| Father | Yes | [ ]  | No | [ ]  | Mother | Yes | [ ]  | No | [ ]  |
|       |       |
| **Did either parent experience any kind of learning difficulties at school? Please specify.** |
| Father | Yes | [ ]  | No | [ ]  | Mother | Yes | [ ]  | No | [ ]  |
|       |       |
| **Did either parent or extended family member (brother, cousin, etc) experience a reading or spelling problem?** |
| Father’s side | Yes | [ ]  | No | [ ]  | Mother’s side | Yes | [ ]  | No | [ ]  |
|       |       |
| **Does anyone in the family have a speech, language and/or hearing problem?** |
| Father’s side | Yes | [ ]  | No | [ ]  | Mother’s side | Yes | [ ]  | No | [ ]  |
|       |       |
| **Is your child left handed? (select yes or no answer)** | Yes | [ ]  | No | [ ]  |
| **Is any other family member left handed?** |
| Father’s side | Yes | [ ]  | No | [ ]  | Mother’s side | Yes | [ ]  | No | [ ]  |
|       |       |
| **Has the child or the family ever experienced any trauma eg? Death of a loved one, divorce, hijacking, violence etc? Please give details.** |
|       |

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| **Family Relationship** *(Please describe the following)* |
| **Marital relationship** |
|       |
| **Relationship of child with father** |
|       |
| **Relationship of child with mother** |
|       |
| **Relationship of child with siblings** |
|       |
| **Other significant role players** |
|       |
| **Discipline** |
| **Who disciplines at home and how?** | Father | [ ]  | Mother | [ ]  |
| **Is it consistent?** | Yes | [ ]  | No | [ ]  |
| **What discipline problems do you experience with your child? *(Please specify below)*** |
|       |

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| **Previous Assessments****Consultation with / referral to Educational or Health Professionals** |
| *Please state whether your child has had any previous testing (eg. psychological, educational) and if so, by whom and when? It is important for the assessor to know what tests have been done on your child. Some may not be repeated as they require a set period before retesting may occur.* |
| **Paediatrician** |
| **Name and Surname**  |       |
| **Contact Number**  |       | **Consultation Date** |       |
| **Email Address**  |       |
| **Report Attached**  | Yes [ ]  | No [ ]  |  |
| **Reason**  |       |
| **Findings**  |       |
| **Medication**  |       |
| **Neurologist** |
| **Name and Surname**  |       |
| **Contact Number**  |       | **Consultation Date** |       |
| **Email Address** |  |
| **Report Attached** | Yes [ ]  | No [ ]  |  |
| **Reason**  |       |
| **Findings**  |       |
| **Medication**  |       |
| **Psychiatrist** |
| **Name and Surname**  |       |
| **Contact Number**  |       | **Consultation Date** |       |
| **Email Address**  |       |
| **Report Attached**  | Yes [ ]  | No [ ]  |
| **Reason**  |       |
| **Findings**  |       |
| **Medication**  |       |

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| **Occupational Therapist** |
| **Name and Surname**  |       |
| **Contact Number**  |       | **Therapy Date** |       |
| **Email Address**  |       |
| **Report Attached**  | Yes [ ]  | No [ ]  |
| **Is therapy currently underway** | If yes, name of Occupational Therapist / consulting professional      |
| If no, termination date and reasons      |
| **Recommendations** |       |
| **Speech Therapist** |
| **Name and Surname**  |       |
| **Contact Number**  |       | **Therapy Date** |       |
| **Email Address**  |       |
| **Report Attached** | Yes [ ]  | No [ ]  |
| **Is therapy currently underway**  | If yes, name of Speech Therapist / consulting professional      |
| If no, termination date and reasons      |
| **Recommendations**  |       |
| **Physiotherapist** |
| **Name and Surname**  |       |
| **Contact Number**  |       | **Therapy Date** |       |
| **Email Address**  |       |
| **Report Attached** | Yes [ ]  | No [ ]  |
| **Is therapy currently underway**  | If yes, name of consulting professional      |
| If no, termination date and reasons      |
| **Recommendations** |       |
| **Remedial Therapist** |
| **Name and Surname**  |       |
| **Contact Number**  |       | **Therapy Date** |       |
| **Email Address**  |       |
| **Report Attached** | Yes [ ]  | No [ ]  |
| **Is therapy currently underway**  | If yes, name of Remedial Therapist / consulting professional      |
| If no, termination date and reasons      |
| **Recommendations**  |       |
| **School Psychologist Service** |
| **Name**  |       |
| **Contact Number**  |       | **Therapy Date** |       |
| **Email Address**  |       |
| **Reason**  |       |
| **Findings**  |       |

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| **Do you give us permission to invite the above therapists to the Case Conference? (Please select Yes or No)**  | **YES** | [ ]  | **NO** | [ ]  |

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| **Developmental History****Pregnancy and Birth** |
| Please select the appropriate column **and comment**. |
| PREGNANCY | **Yes** | **No** | **Comment** |
| **1. Were there any miscarriages/still births?** | [ ]  | [ ]  |       |
| **2. Was your baby planned?**  | [ ]  | [ ]  |       |
| **3. How long had you been married when the baby was born?** | [ ]  | [ ]  |       |
| **4. Did mother have physical and/or emotional problems during pregnancy? eg. flu, infections, unusual tension or trauma? If so, please elaborate.** | [ ]  | [ ]  |       |
| **5. Were any medications taken during the pregnancy?** **If yes, what were they?** | [ ]  | [ ]  |       |
| **6. Were X-rays and scans taken?** **How many?**       | [ ]  | [ ]  |       |
| **7. Smoked during pregnancy?** | [ ]  | [ ]  |       |
| **8. Drank during pregnancy?** | [ ]  | [ ]  |       |
| BIRTH | **Yes** | **No** | **Comment** |
| **1.Please state whether your baby was premature, full term or post-mature** | [ ]  | [ ]  |       |
| **2. Where was the baby born (name hospital where appropriate)** | [ ]  | [ ]  |       |
| **3. Was there a prolonged labour?** | [ ]  | [ ]  |       |
| **4. Was there any foetal distress?** | [ ]  | [ ]  |       |
| **5. Forceps used?** | [ ]  | [ ]  |       |
| **6. Cord around neck?** | [ ]  | [ ]  |       |
| **7. Caesarian section? Why?** | [ ]  | [ ]  |       |
| **8. Was an incubator used? For how long?** **Could parents touch baby in the incubator?** | [ ]  | [ ]  |       |
| **9. What was the Apgar rating? At 1 minute?**       **At 5 minutes?**       | / | / |       |
| **10. What was the birth weight?** | / | / |       |
| **11. Were there breathing difficulties? Was oxygen administered?** | [ ]  | [ ]  |       |
| **12. Initial jaundice?** **(a) Was the baby put under lights?** **(b) For how long?**       | [ ]  | [ ]  |       |
| **13. Did mother and baby go home together?****(a) If not, did mother visit daily?****(b) How long did baby remain in hospital?** | [ ]  | [ ]  |       |
| **14. Did mother breast feed at hospital or express milk to take it into the hospital?** | [ ]  | [ ]  |       |
| **15. Post natal depression?** **For how long?**       **Was any treatment necessary?****Were there any problems in bonding?**  | [ ]  | [ ]  |       |

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| **Infancy** |
| **Did your baby experience** | **Yes** | **No** | **Comment** |
| **1. Feeding problems** **Who advised?**      **How many formulas tried?**      **Did you stick rigidly to 4 hour feeding or did you feed on demand?**       | [ ]  | [ ]  |       |
| **2. Colic****Was there excessive crying?** **Did it last 3 months or was it longer?**      **How did this make you feel?** | [ ]  | [ ]  |       |
| **3. Disturbed Sleep Patterns** | [ ]  | [ ]  |       |
| **4. Eczema, Asthma, other allergies** | [ ]  | [ ]  |       |
| **5. Did you notice that at times your baby seemed to be floppy or very stiff?** | [ ]  | [ ]  |       |
| **6. When did you start toilet training?** | / | / |       |
| **7. When was he dry during the day?** | / | / |       |
| **8. When was he dry during the night?** | / | / |       |

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| **Baby’s behaviour** (please select appropriate answers) |
| Difficult | Content | Sleepy aggression | Head banging | Temper tantrums | Rocking | Breath holding |
| [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **Emotional Development** |
| **In his first three years, did your child :** | **Yes** | **No** | **Comment** |
| **1. Suck a dummy?** | [ ]  | [ ]  |       |
| **2. Bite his/her nails?** | [ ]  | [ ]  |       |
| **3. Suck his/her thumb?** | [ ]  | [ ]  |       |
| **4. Have a special toy/blanket?** | [ ]  | [ ]  |       |
| **5. Masturbate heavily?****How did you deal with this?** | [ ]  | [ ]  |       |
| **6. Hair pluck? Where?** | [ ]  | [ ]  |       |
| **7. Head bang?** | [ ]  | [ ]  |       |
| **8. Have specific fears?** **What are they? Is there a realistic origin?** | [ ]  | [ ]  |       |
| **9. Have nightmares?****Does he/she sleep with the light on?** | [ ]  | [ ]  |       |
| **10. Have tantrums?****How do you deal with these?** | [ ]  | [ ]  |       |
| **11. Bed-wetting problems?****Could you say when he wets the bed?****In the early hours or later?**      **Is there any thrashing about in bed?**  | [ ]  | [ ]  |       |
| **12. Soiling problems?**  | [ ]  | [ ]  |       |

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| **Comment on any of the above habits that still continue** |
|       |
| **Are these, in your opinion, related to school? If not, what do you think causes this at home?** |
|       |
| **Is your child easily frustrated?** | Yes | [ ]  | No | [ ]  |
| **Is he overly sensitive or emotional?** | Overly Sensitive | [ ]  | Emotional | [ ]  |
| **Medical History** |
| *Please give the following details:* |
| **Details** | **Name** | **Date** | **Comments**(including changes in behaviour) |
| **Childhood illnesses** |       |       |       |
| **Operations** |       |       |       |
| **Allergies** |       |       |       |
| Has your child had a *thorough medical examination recently by a paediatrician*?  | Yes | [ ]  | No | [ ]  |
| **If yes,** please fill in the following |
| **By Whom** |       |
| **When** |       |
| **What were the findings?** |       |
| **Record of Medication** |
| Year | **Type of medication****and dosage** | Prescribed by | **Behavioural changes** |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |

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| **Please attach reports for the below testing; failing to do so will result in a delay regarding assessments.** |
| **Auditory / Sound - HEARING TEST** |
| **By Whom** |       |
| **Date** |       |
| **Findings** |       |
| **Does your child:** | **Yes** | **No** | **Comment** |
| * **Seem to hear sounds unnoticed by other children/adults?**
 | [ ]  | [ ]  |       |
| * **Seem to be very sensitive to sounds, eg, refrigerator, fluorescent lights, heaters?**
 | [ ]  | [ ]  |       |
| * **Seem confused as to the direction from which a sound comes?**
 | [ ]  | [ ]  |       |
| **Visual System - EYE TEST** |
| **By Whom** |       |
| **Date** |       |
| **Findings** |       |
| **Does your child:** | **Yes** | **No** | **Comment** |
| * **Have a diagnosed visual defect?**

**-how has this been treated/corrected?*** **Wear glasses?**
 | [ ] [ ]  | [ ] [ ]  |       |
| **If yes,** **please ensure that they are brought with to the assessments** | [ ]  | [ ]  |       |
| * **Seem to have difficulty following a moving object?**
 | [ ]  | [ ]  |       |
| * **Make reversals when copying?**
 | [ ]  | [ ]  |       |
| * **Appear to be sensitive to light/sunlight?**
 | [ ]  | [ ]  |       |
| * **Resist having his/her eyes closed/covered?**
 | [ ]  | [ ]  |       |
| * **Blink his/her eyes continuously?**
 | [ ]  | [ ]  |       |
| * **Are his/her eyes continually red/watery?**
 | [ ]  | [ ]  |       |
| * **Tend to work with his/her head close to the table?**
 | [ ]  | [ ]  |       |
| * **Become excited/confused when confronted by a variety of visual stimuli/objects?**
 | [ ]  | [ ]  |       |
| **Motor Milestones** |
| **Approximately when did the following occur?** | **Age/Comment** |
| *(If you cannot recall exact ages, did it appear to be the same as other children or earlier or later?)* |
| * **smile**
 |       |
| * **hold head up**
 |       |
| * **roll over**
 |       |
| * **sit by himself without help**
 |       |
| * **crawl**
	+ **in what way?**
	+ **for how long did he/she crawl?**
 |       |
| * **walk**
 |       |
| * **ride a tricycle**
 |       |
| * **ride a bicycle without “fairy” wheels**
 |       |
| * **Did your child use a walking ring?** Yes [ ]  No [ ]
* **If yes, at what age did the child start using it**
* **at what age did the child stop using it?**
* **for how long each day was he/she in it?**
 |       |
| **Did your child use a jolly jumper?** Yes [ ]  No [ ]  |       |
| * **Does your child enjoy jungle gym equipment and other outdoor activities?** Yes [ ]  No [ ]
 |       |
| **Functional Tasks:** | **Yes** | **No** | **Age/Comment** |
| * **Does your child dress/undress him/herself?**
 | [ ]  | [ ]  |       |
| * **Does your child experience difficulty with shoelaces or buttons, putting on a T-shirt or sweater?**
 | [ ]  | [ ]  |       |
| * **Is your child a messy eater?**
 | [ ]  | [ ]  |       |
| * **Where does your child eat?** at the table, [ ]  with the family [ ]  or alone? [ ]
* **At what time?**
 | [ ]  | [ ]  |       |
| * **Does your child bath independently?**
 | [ ]  | [ ]  |       |
| * **Brush teeth independently?**
 | [ ]  | [ ]  |       |
| * **Use the toilet independently?**
 | [ ]  | [ ]  |       |
| **Sensorimotor History:** |
| *If there have been noteworthy changes or alterations in the following behaviours, please comment on these as this could help the therapist.* |
| **1. Tactile sensation -**  does your child : | **Yes** | **No** | **Comment** |
| * **Dislike being touched?**
 | [ ]  | [ ]  |       |
| * **Prefer to touch than to be touched?**
 | [ ]  | [ ]  |       |
| * **Dislike being cuddled/hugged?**
 | [ ]  | [ ]  |       |
| * **Seem irritable when held?**
 | [ ]  | [ ]  |       |
| * **Have a strong need to touch people, objects and/or animals?**
 | [ ]  | [ ]  |       |
| * **Seem easily irritated or enraged when touched by siblings or playmates?**
 | [ ]  | [ ]  |       |
| * **Frequently push/bump other children (eg. when standing in a line)?**
 | [ ]  | [ ]  |       |
| * **Seem to pick fights at school (eg. standing in line, on the playground)?**
 | [ ]  | [ ]  |       |
| * **Isolate him/herself from other children?**
 | [ ]  | [ ]  |       |
| * **React negatively to the feel of new clothes/labels on collars/textures of clothes?**
 | [ ]  | [ ]  |       |
| * **Seem unaware of excessive temperature (eg. wear a sweater in summer?)**
 | [ ]  | [ ]  |       |
| * **Dislike having hair and/or face washed?**
 | [ ]  | [ ]  |       |
| * **Dislike having a haircut?**
 | [ ]  | [ ]  |       |
| * **Object strongly to having his/her nails cut?**
 | [ ]  | [ ]  |       |
| * **Dislike being dirty or sticky? Will he/she play with clay, mud, etc.?**
 | [ ]  | [ ]  |       |
| * **Avoid taking off his/her shoes and walking barefoot on grass, sand, etc.?**
 | [ ]  | [ ]  |       |
| * **Seem extremely brave or almost unaware of painful experiences, eg, stitches, injections, bruises, cuts?**
 | [ ]  | [ ]  |       |
| **2. Taste and Smell** - does your child : | **Yes** | **No** | **Comment** |
| * **Identify odours?**
 | [ ]  | [ ]  |       |
| * **Ignore/react strongly to bad smells?**
 | [ ]  | [ ]  |       |
| * **Is your child overly sensitive to different smells?**
 | [ ]  | [ ]  |       |
| * **Refuse to try new foods?**
 | [ ]  | [ ]  |       |
| * **dislike food or certain textures (eg, rough, food that needs to be chewed, sherbet)**
 | [ ]  | [ ]  |       |
| * **Only eat foods that are smooth with no lumps?**
 | [ ]  | [ ]  |       |
| * **Act as if all foods taste the same?**
 | [ ]  | [ ]  |       |
| * **Explore the environment by tasting/putting everything into his/her mouth?**
 | [ ]  | [ ]  |       |
| * **Refuse to co-operate at the dentist?**
 | [ ]  | [ ]  |       |
| * **Dislike brushing teeth?**
 | [ ]  | [ ]  |       |
| **3. Vestibular** - does your child : | **Yes** | **No** | **Comment** |
| * **Enjoy being rocked?**
 | [ ]  | [ ]  |       |
| * **Is/was your child scared when you playfully throw/threw him/her up in the air and catch/caught him/her?**
 | [ ]  | [ ]  |       |
| * **Seem fearful of space, eg, going up and down stairs, escalators, lifts, etc.?**
 | [ ]  | [ ]  |       |
| * **Appear to be clumsy and often bump into things and/or fall down?**
 | [ ]  | [ ]  |       |
| * **Enjoy fast moving, rolling, spinning movements and/or rides?**
 | [ ]  | [ ]  |       |
| * **Tend to avoid balance activities such as climbing over chairs, balance beams?**
 | [ ]  | [ ]  |       |
| * **Avoid jungle gyms and outdoor climbing activities?**
 | [ ]  | [ ]  |       |
| * **Dislike riding on an adult’s shoulders?**
 | [ ]  | [ ]  |       |
| * **Get car sick easily?**
 | [ ]  | [ ]  |       |
| * **Are your child’s movements slow, plodding and/or deliberate?**
 | [ ]  | [ ]  |       |
| **4. Co-ordination** - does your child : | **Yes** | **No** | **Comment** |
| * **Seem to be in perpetual motion from the time he/she wakes until bedtime?**
 | [ ]  | [ ]  |       |
| * **Manipulate small objects with his/her fingers?**
 | [ ]  | [ ]  |       |
| * **Seem accident prone, ie, have frequent bumps, bruises, scratches?**
 | [ ]  | [ ]  |       |
| * **Eat in a sloppy manner?**
 | [ ]  | [ ]  |       |
| * **Does he/she use a spoon, knife, fork correctly?**
 | [ ]  | [ ]  |       |
| * **Have difficulty with pencil activities, eg, colouring in, outlining?**
 | [ ]  | [ ]  |       |
| * **Appear to tire easily?**
 | [ ]  | [ ]  |       |
| * **Has your child established a consistent hand dominance? Which hand does he/she prefer?**
 | [ ]  | [ ]  |       |
| * **Seem to ignore one side of the body?**
* **Which side?**
 | [ ]  | [ ]  |       |
| * **Appear to have difficulty with tasks requiring a sequence of movements, eg, dressing?**
 | [ ]  | [ ]  |       |
| * **Have noticeable tongue movements when concentrating hard?**
 | [ ]  | [ ]  |       |
| * **Appear to be stronger or weaker than other children of a similar age?**
 | [ ]  | [ ]  |       |
| * **frequently grasp objects too loosely or too tight**
 | [ ]  | [ ]  |       |
| **5. Play** - does your child : | **Yes** | **No** | **Comment** |
| * **Play in a constructive or destructive manner?**
 | [ ]  | [ ]  |       |
| * **Play out of his/her own volition/initiative or does he/she need to be constantly guided/led?**
 | [ ]  | [ ]  |       |
| * **Is he/she organised in his/her approach to an activity/task or does he/she work in a haphazard manner?**
 | [ ]  | [ ]  |       |
| * **Use the toys/equipment appropriately for his/her age?**
 | [ ]  | [ ]  |       |
| * **When playing, will he/she first attempt the game or will he/she rather watch others before attempting it him/herself?**
 | [ ]  | [ ]  |       |
| * **Are your child’s movements flowing or is there poor judgement of timing?**
 | **[ ]**  | **[ ]**  |  |
| * **First make something and only thereafter decide what it is?**
 | [ ]  | [ ]  |       |
| * **Is your child’s play repetitive or varied?**
 | [ ]  | [ ]  |       |
| * **take risks or does he/she prefer to “play it safe”**
 | [ ]  | [ ]  |       |
| **Any other important aspects of development which you feel would assist the therapist:** |
|       |
| **Please ensure that your child wears “takkies”, running shoes or closed shoes for the Occupational Therapy Assessment** |
| **Speech Milestones** |
| **Medical History** |
| **Has your child suffered from ear infections?** | **Never** | **Seldom** | **Frequently** |
| **0 – 3 years** | [ ]  | [ ]  | [ ]  |
| **3 – 6 years** | [ ]  | [ ]  | [ ]  |
| **Above 6 years** | [ ]  | [ ]  | [ ]  |
| **When was the last ear infection?** |       |
| **By whom was it treated and how? (complete below)** |
| **Whom** |       | **How** |       |
| **Is there a family speech problem?** Yes [ ]  No [ ]  Please give full details. |
|       |
| **Speech Language Milestones (select correct answer)** |
| **Did your baby cry at birth?** | Yes | [ ]  | No | [ ]  |
| **Was he an abnormally quiet baby? (Not just a contented)** | Yes | [ ]  | No | [ ]  |
| **Did your baby respond to sounds?** | Yes | [ ]  | No | [ ]  |
| **Was he able to imitate sounds?** | Yes | [ ]  | No | [ ]  |
| **Please give approximate dates (eg. 11 months) to the following:** | **Dates** |
| * **Babbling**
 |       |
| * **First Words**
 |       |
| * **Sentences**
 |       |
| **At Present** |
| **Does your child show understanding when spoken to?** | Yes | [ ]  | No | [ ]  |
| **What makes you certain of this?** |
|       |

|  |
| --- |
| **How do you rate your child's vocabulary in comparison with others of his age?** |
|       |
| **When your child speaks** |
| * **Does he express himself fluently**
 | Yes | [ ]  | No | [ ]  |
| * **In long sentences**
 | Yes | [ ]  | No | [ ]  |
| * **With a good vocabulary**
 | Yes | [ ]  | No | [ ]  |
| * **Is he easily understood by others?**
 | Yes | [ ]  | No | [ ]  |

|  |
| --- |
| **RELEASE FORM** |
| **PREVIOUS ASSESSMENT REPORTS SHOULD ACCOMPANY THIS QUESTIONNAIRE.*****ONLY IN SIGNING THIS FORM YOU GIVE US PERMISSION TO CONTINUE WITH THE PROCESS*** |
| In order that we can provide you and your child with the maximum assistance, it is important that we have as much information as possible concerning the developmental history of your child. This includes information concerning difficulties experienced by your child as well as results of any medical, psychological or any other professional testing. You are entitled to seek an assessment even if your child is currently in therapy with another therapist.To obtain reports on the results of any tests, or to forward any information, we require your permission in writing. We assure you that all information on your family and your child will be kept strictly confidential. It is important for the assessor to know what tests have been done on your child as some may not be repeated, or they may require a set period before retesting may occur. |
| 1) I hereby authorise the release of any information with regard to  (name of pupil) to Bellavista Assessment Centre. |
| 2) I hereby declare that all the information provided is to the best of my knowledge, accurate and true. |
|  |
| **SIGNED:** |       | in the capacity of parents or guardian. |
| **FATHER FULL NAME:** |       | **DATE:** |       |
|  |
|  |
| **SIGNED:** |       | in the capacity of parents or guardian. |
| **MOTHER FULL NAME:** |       | **DATE:** |       |
|  |
|  |
| **PAYMENT REQUIREMENTS** |
| Payment of R850.00 administrative fee |
| **Payment by EFT to:**  | Bellavista School |
| **Bank:** | Standard Bank |
| **Branch:** | Rosebank Branch |
| **Branch Code:** | 004305 |
| **Account Number:** | 001986686 |
| **Please reference your payment as follows:** | Child’s name / admin fee |
| **Proof of payment to be provided** |