



BELLAVISTA
•S•E•E•K•
EDUCATION ASSESSMENT CENTRE

35 Wingfield Avenue Birdhaven Johannesburg
PO Box 55017 Northlands 2116
Tel (011) 788 5454 Fax (011) 880 2674
www.bellavista.org.za

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 it 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 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? | | | |

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

| 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 | |
| Grades repeated | |
| Medium of instruction, e.g., Eng | |
| 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 |
| Nursery School | | | | |
| Primary School | | | | |
| High School | | | | |

| School readiness | | | |
|--|-----|--------------------------|-----------------------------|
| Was your child considered ready for GrR Primary School? | Yes | <input type="checkbox"/> | No <input type="checkbox"/> |
| Was a school readiness assessment conducted? | Yes | <input type="checkbox"/> | No <input type="checkbox"/> |
| 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?

| |
|--|
| |
|--|

| |
|-----------------------------|
| Parental Information |
|-----------------------------|

| |
|---------------|
| Parent |
|---------------|

| | |
|---|--|
| Title and surname | |
| First 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? | |

| |
|---------------|
| Parent |
|---------------|

| | |
|---|--|
| Title and surname | |
| First 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? | |

| |
|---|
| Other significant person's description (Grandparent, AuPair, etc.) |
| |

| Your child now – at home | | | |
|--|--------------------------------------|--------------------------------------|---|
| (Please select <input checked="" type="checkbox"/> the correct answer) | | | |
| Sleep | | | |
| Restless <input type="checkbox"/> | Regular <input type="checkbox"/> | Nightmares <input type="checkbox"/> | Bedwetting <input type="checkbox"/> Sleepwalking <input type="checkbox"/> |
| Eating | | | |
| Good appetite <input type="checkbox"/> | | Fussy eater <input type="checkbox"/> | |
| Habits | | | |
| Thumb sucking <input type="checkbox"/> | Nail biting <input type="checkbox"/> | Twitching <input type="checkbox"/> | Other <input type="checkbox"/> |
| Does your child appear to concentrate for an extended period of time, e.g, playing, watching TV? | | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you have to continually repeat instructions? | | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Does your child get distracted easily? | | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| How do you rate the following? | | | |
| Concentration | Good <input type="checkbox"/> | Average <input type="checkbox"/> | Poor <input type="checkbox"/> |
| Activity level | Overactive <input type="checkbox"/> | Normal <input type="checkbox"/> | Poor <input type="checkbox"/> |
| Talks | Too much <input type="checkbox"/> | Average <input type="checkbox"/> | Too Little <input type="checkbox"/> |
| Fidgets | A lot <input type="checkbox"/> | A little <input type="checkbox"/> | Not at all <input type="checkbox"/> |
| Socially: | | | |
| Does your child prefer to play alone? | | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Does your child like to have the company of friends? | | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Does your child interact well with friends? | | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| What age group does your child prefer to play with? | | Older <input type="checkbox"/> | Younger <input type="checkbox"/> Both <input type="checkbox"/> |
| How does your child interact with family members? | | | |
| | | | |
| How does your child interact with other adults? | | | |
| | | | |
| Present Concerns | | | |
| Please state person and/or organisation who made the referral, e.g., 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? |
| |

| Parent's Education | | | | | | | | | |
|---|-----|--------------------------|----|--------------------------|---------------------|-----|--------------------------|----|--------------------------|
| Parent | | | | | | | | | |
| Primary Education | | | | | | | | | |
| High School | | | | | | | | | |
| Tertiary Education | | | | | | | | | |
| Parent | | | | | | | | | |
| 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? | | | | | | | | | |
| Parent | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | Parent | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| | | | | | | | | | |
| Now, as an adult, do you find it difficult to sustain attention? | | | | | | | | | |
| Parent | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | Parent | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| | | | | | | | | | |
| Did either parent experience any kind of learning difficulties at school? Please specify. | | | | | | | | | |
| Parent | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | Parent | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| | | | | | | | | | |
| Did either parent or extended family member (brother, cousin, etc) experience a reading or spelling problem? | | | | | | | | | |
| What parent's side? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | What parent's side? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| | | | | | | | | | |

| | | | | | |
|--|-----|--------------------------|----|--------------------------|--|
| Does anyone in the family have a speech, language and/or hearing problem? | | | | | |
| What parent's side? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | |
| | | | | What parent's side? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| | | | | | |
| Is your child left handed? (select yes or no answer) | | | | Yes | <input type="checkbox"/> |
| Is any other family member left handed? | | | | No | <input type="checkbox"/> |
| What parent's side? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> | |
| | | | | What parent's side? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| | | | | | |
| Has the child or the family ever experienced any trauma, e.g., Death of a loved one, divorce, hijacking, violence etc? Please give details. | | | | | |
| | | | | | |

| | |
|--|--|
| Family Relationships <i>(Please describe the following)</i> | |
| Marital relationship | |
| | |
| Relationship of child with parent | |
| | |
| Relationship of child with parent | |
| | |
| Relationship of child with siblings | |
| | |
| Other significant role players | |
| | |

| Discipline | | |
|---|---------------------------------|---------------------------------|
| Who disciplines at home and how? | Parent <input type="checkbox"/> | Parent <input type="checkbox"/> |
| Is it consistent? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| What discipline problems do you experience with your child? <i>(Please specify below)</i> | | |
| | | |

Assessments

Please state whether your child has had any previous assessment (e.g. psychological, educational) and if so, by whom and when? It is important for the various assessors 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 <input type="checkbox"/> | No <input type="checkbox"/> | |
| Reason | | | |
| Findings | | | |
| Medication | | | |
| Neurologist | | | |
| Name and Surname | | | |
| Contact Number | | Consultation Date | |
| Email Address | | | |
| Report Attached | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| Reason | | | |
| Findings | | | |
| Medication | | | |

| Psychiatrist | | | |
|------------------|------------------------------|-----------------------------|--|
| Name and Surname | | | |
| Contact Number | | Consultation Date | |
| Email Address | | | |
| Report Attached | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| Reason | | | |
| Findings | | | |
| Medication | | | |

| Occupational Therapist | | | |
|--------------------------------|--|------------------------------|-----------------------------|
| Name and Surname | | | |
| Contact Number | | Therapy Date | |
| Email Address | | | |
| Report Attached | | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Is therapy currently underway? | If yes, name of Occupational Therapist / consulting professional | | |
| | If no, termination date and reasons | | |
| Recommendations | | | |
| Speech-Language Therapist | | | |
| Name and Surname | | | |
| Contact Number | | Therapy Date | |
| Email Address | | | |
| Report Attached | | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Is therapy currently underway? | If yes, name of consulting professional | | |
| | If no, termination date and reason | | |
| Recommendations | | | |

| Physiotherapist or any other early intervention | | | |
|---|---|------------------------------|-----------------------------|
| Name and Surname | | | |
| Contact Number | | Therapy Date | |
| Email Address | | | |
| Report Attached | | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 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 <input type="checkbox"/> | No <input type="checkbox"/> |
| Is therapy currently underway? | If yes, name of consulting professional | | |
| | If no, termination date and reasons | | |
| Recommendations | | | |

| School Psychologist Service | | | |
|-----------------------------|--|--------------|--|
| Name | | | |
| Contact Number | | Therapy Date | |
| Email Address | | | |
| Reason | | | |
| Findings | | | |

| | | |
|---|------------------------------|-----------------------------|
| Do you give us permission to contact the above therapists to the (Please select Yes or No) | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
|---|------------------------------|-----------------------------|

Developmental History

Pregnancy and Birth

Please select the appropriate column and comment.

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

| Infancy | | | | | | |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|--------------------------|
| Did your baby experience | Yes | No | Comment | | | |
| 1. Feeding problems | <input type="checkbox"/> | <input type="checkbox"/> | Who advised? _____ How many formulas were tried? ____ Did you stick rigidly to 4 hour feeding or feed on demand? _____ | | | |
| 2. Colic | <input type="checkbox"/> | <input type="checkbox"/> | Was there excessive crying? ____ Did it last 3 months or was it longer? _____ How did this feel? _____ | | | |
| 3. Disturbed sleep patterns | <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| 4. Eczema, asthma, other allergies | <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| 5. Did you notice that at times your baby seemed floppy or very stiff? | <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| 6. When did you start toilet training? | / | / | | | | |
| 7. When was your child dry during the day? | / | / | | | | |
| 8. When was your child dry during the night? | / | / | | | | |
| Baby's Behaviour (please select appropriate answers) | | | | | | |
| Difficult | Content | Sleepy | Head banging | Temper tantrums | Rocking | Breath holding |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| Emotional Development | | | |
|--|--------------------------|--------------------------|---|
| In the first three years, did your child : | Yes | No | Comment |
| 1. Suck a dummy? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2. Bite his/her nails? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3. Suck his/her thumb? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 4. Have a special toy/blanket? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 5. Masturbate heavily? | <input type="checkbox"/> | <input type="checkbox"/> | If yes, how did you deal with this? |
| 6. Hair pluck? Where? | <input type="checkbox"/> | <input type="checkbox"/> | If yes, where? |
| 7. Head bang? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 8. Have specific fears? | <input type="checkbox"/> | <input type="checkbox"/> | What are they? Is there a realistic origin? |
| 9. Have nightmares? Does the child sleep with the light on? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 10. Have tantrums? | <input type="checkbox"/> | <input type="checkbox"/> | If yes, how do you deal with these? |
| 11. Bed-wetting problems? | <input type="checkbox"/> | <input type="checkbox"/> | In the early hours or later? Is there any thrashing about in bed? |
| 12. Soiling problems? | <input type="checkbox"/> | <input type="checkbox"/> | |

| | | | |
|--|---|------------------------------------|-----------------------------|
| 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 <input type="checkbox"/> | No <input type="checkbox"/> |
| Is he overly sensitive or emotional? | Overly Sensitive <input type="checkbox"/> | Emotional <input type="checkbox"/> | |

Medical History

Please provide the following details:

| Details | Description | Date identified | Comments (incl. changes in behaviour) |
|--------------------------|-------------|-----------------|---------------------------------------|
| Childhood illness | | | |
| Surgeries | | | |
| Allergies | | | |

Has your child had a thorough medical examination by a paediatrician? Yes _____ No _____

If yes, please complete:

| | |
|--------------------------------|--|
| By whom? | |
| When? | |
| What were the findings? | |

Record of Medication

| Year | Medication name and dosage | Prescribed by | Response incl. Behaviour where applicable. |
|------|----------------------------|---------------|--|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Please attach reports for the below testing; failing to do so may result in a delay regarding assessments.

| Visual System - EYE TEST | | | |
|---|---|--------------------------|---|
| By Whom | | | |
| Date | | | |
| Findings | | | |
| Does your child: | Yes | No | Comment |
| Have a diagnosed visual defect? | <input type="checkbox"/> | <input type="checkbox"/> | How has this been treated/corrected? |
| Wear glasses? | <input type="checkbox"/> | <input type="checkbox"/> | If yes, please ensure that they are brought with to the assessments |
| Seem to have difficulty following a moving object? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Make reversals when copying? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Appear to be sensitive to light/sunlight? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Resist having eyes closed/covered? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Blink eyes continuously? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Are eyes continually red/watery? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Tend to work with head close to the table? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Become excited/confused when confronted by a variety of visual stimuli/objects? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Motor Milestones | | | |
| Approximately when did the following occur? | Age/Comment | | |
| <i>(If you cannot recall exact ages, did it appear to be the same as other children or earlier or later?)</i> | | | |
| Smile | | | |
| Hold head up | | | |
| Roll over | | | |
| Sit by himself without help | | | |
| Crawl | In what way? _____ For how long? _____ | | |
| Walk | | | |
| Ride a tricycle | | | |
| Ride a bicycle without "fairy" wheels | | | |
| Did your child use a walking ring? | Yes <input type="checkbox"/> No <input type="checkbox"/> If yes: At what age did the child <u>start</u> using it? _____ At what age did the child <u>stop</u> using it? _____ For how long each day was he/she in it? _____ | | |
| Did your child use a jolly jumper? | Yes <input type="checkbox"/> No <input type="checkbox"/> | | |
| Does your child enjoy jungle gym equipment and other outdoor activities? | Yes <input type="checkbox"/> No <input type="checkbox"/> | | |
| Functional Tasks: | Yes | No | Age/Comment |
| Does your child dress/undress him/herself? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Does your child experience difficulty with shoelaces or buttons, putting on a T-shirt or sweater? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Is your child a messy eater? | <input type="checkbox"/> | <input type="checkbox"/> | |

| | | | |
|--|---|--------------------------|----------------|
| Where does your child eat? | At the table, <input type="checkbox"/> with the family <input type="checkbox"/> or alone? <input type="checkbox"/> At what time? _____ | | |
| Does your child bath independently? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Brush teeth independently? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Use the toilet independently? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Sensorimotor History: | | | |
| <i>If there have been noteworthy changes or alterations in the following behaviours, please comment on these as this could help the therapist.</i> | | | |
| Tactile sensation- does your child : | Yes | No | Comment |
| Dislike being touched? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Prefer to touch than to be touched? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Dislike being cuddled/hugged? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Seem irritable when held? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Have a strong need to touch people, objects and/or animals? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Seem easily irritated or enraged when touched by siblings or playmates? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Frequently push/bump other children (eg. when standing in a line)? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Seem to pick fights at school (e.g. standing in line, on the playground)? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Isolate him/herself from other children? | <input type="checkbox"/> | <input type="checkbox"/> | |
| React negatively to the feel of new clothes/labels on collars/textures of clothes? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Seem unaware of excessive temperature (eg. wear a sweater in summer?) | <input type="checkbox"/> | <input type="checkbox"/> | |
| Dislike having hair and/or face washed? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Dislike having a haircut? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Object strongly to having his/her nails cut? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Dislike being dirty or sticky? Will he/she play with clay, mud, etc.? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Avoid taking off his/her shoes and walking barefoot on grass, sand, etc.? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Seem extremely brave or almost unaware of painful experiences, e.g. stitches, injections, bruises, cuts? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Taste and Smell- does your child: | Yes | No | Comment |
| Identify odours? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Ignore/react strongly to bad smells? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Is your child overly sensitive to different smells? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Refuse to try new foods? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Dislike food or certain textures (eg, rough, food that needs to be chewed, sherbet) | <input type="checkbox"/> | <input type="checkbox"/> | |
| Only eat foods that are smooth with no lumps? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Act as if all foods taste the same? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Explore the environment by tasting/putting everything into his/her mouth? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Refuse to co-operate at the dentist? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Dislike brushing teeth? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Vestibular - does your child : | Yes | No | Comment |
| Enjoy being rocked? | <input type="checkbox"/> | <input type="checkbox"/> | |

| | | | |
|--|--------------------------|--------------------------|--|
| Is your child scared when you playfully throw up in the air and catch? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Seem fearful of space, eg, going up and down stairs, escalators, lifts, etc.? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Appear to be clumsy and often bump into things and/or fall down? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Enjoy fast moving, rolling, spinning movements and/or rides? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Tend to avoid balance activities such as climbing over chairs, balance beams? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Avoid jungle gyms/ outdoor climbing activities? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Dislike riding on an adult's shoulders? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Get car sick easily? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Are your child's movements slow, plodding and/or deliberate? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Co-ordination -does your child: | Yes | No | Comment |
| Seem to be in perpetual motion from the time he/she wakes until bedtime? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Manipulate small objects with his/her fingers? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Seem accident prone, ie, have frequent bumps, bruises, scratches? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Eat in a sloppy manner? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Does he/she use a spoon, knife, fork correctly? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Have difficulty with pencil activities, eg, colouring in, outlining? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Appear to tire easily? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Has your child established a consistent hand dominance? | <input type="checkbox"/> | <input type="checkbox"/> | If yes, which hand does he/she prefer? |
| Seems to ignore one side of the body? | <input type="checkbox"/> | <input type="checkbox"/> | If yes, which side? |
| Appear to have difficulty with tasks requiring a sequence of movements, e.g., dressing? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Have noticeable tongue movements when concentrating hard? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Appear to be stronger or weaker than other children of a similar age? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Frequently grasp objects too loosely or too tight | <input type="checkbox"/> | <input type="checkbox"/> | |
| Play - does your child : | Yes | No | Comment |
| Play in a constructive or destructive manner? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Play out of his/her own volition/initiative or does he/she need to be constantly guided/led? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Organised his/her approach to an activity/task or does he/she work in a haphazard manner? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Use the toys/equipment appropriately for his/her age? | <input type="checkbox"/> | <input type="checkbox"/> | |
| First attempt the game (yes) or rather watch others before attempting it him/herself (no)? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Are your child's movements flowing or is there poor judgement of timing? | <input type="checkbox"/> | <input type="checkbox"/> | |
| First make something and only thereafter decide what it is? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Is your child's play repetitive or varied? | <input type="checkbox"/> | <input type="checkbox"/> | |
| take risks or does he/she prefer to "play it safe" | <input type="checkbox"/> | <input type="checkbox"/> | |

Please ensure that your child wears "takkies", running shoes or closed shoes for the Occupational Therapy Assessment

Auditory System - HEARING TEST

| | | | |
|---|--------------------------|--------------------------|----------------|
| By Whom | | | |
| Date | | | |
| Findings | | | |
| Does your child: | Yes | No | Comment |
| Seem to hear sounds unnoticed by other children/adults? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Seem to be very sensitive to sounds, eg, refrigerator, fluorescent lights, heaters? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Seem confused as to the direction from which a sound comes? | <input type="checkbox"/> | <input type="checkbox"/> | |

Speech-Language Milestones

| | | | |
|--|------------------------------|-----------------------------|--------------------------|
| Has your child suffered from ear infections? | Never | Seldom | Frequently |
| 0 – 3 years | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3 – 6 years | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Above 6 years | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Has your child had episodes of: | Never | Seldom | Frequently |
| Sinus infections | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Throat infections | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Allergies | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| When was the last ear infection? | | | |
| By whom was it treated and how? (complete below) | | | |
| Whom | | How | |
| ENT visits and recommendations? | | | |
| Is there a speech problem within the family? Yes <input type="checkbox"/> No <input type="checkbox"/> Please give full details. | | | |
| | | | |
| Speech-Language Milestones (select correct answer) | | | |
| Did your baby cry at birth? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| Was s/he an abnormally quiet baby? (not just contented) | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| Did your baby respond to sounds? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| Was s/he able to imitate sounds? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | |
| Please give approximate dates, e.g., 11 months) to the following: | Dates | | |
| Babbling | | | |
| First Words | | | |
| Sentences | | | |

| At Present | | |
|---|------------------------------|-----------------------------|
| Does your child show understanding when spoken to? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 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 <input type="checkbox"/> | No <input type="checkbox"/> |
| Use long sentences? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Deploy a good vocabulary? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Is s/he easily understood by others? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Dental Information | | |
| Sore / chipped teeth | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Grinding | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Myobrace / oral appliance use (e.g. plate) | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Tongue tie / lip tie (elaborate) | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Recent dental check up (approximate date): | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Eating | | |
| Chewing / swallowing difficulties | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Noisy / messy eater | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Washing food down | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Choking | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Lips open while eating | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Food/liquid escape from mouth | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Food left over in mouth after swallowing | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Abnormal bowel movements | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Food allergies | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Frequent throat clearing | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Gastric symptoms (burp/hiccup/gas/bloat/pain) | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Food preferences | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Oral Habits. Note frequency, intensity, duration, start and end dates | | |
| Thumb sucking | | |
| Pacifier use | | |
| Dry mouth | | |
| Drooling | | |
| Cheek sucking / chewing | | |
| Lip licking / sucking / chewing | | |

| | | |
|---|------------------------------|-----------------------------|
| Tongue sucking / biting | | |
| Nail biting | | |
| Clothing / blanket / item chewing | | |
| Resting teeth on lower lip | | |
| Jaw sliding / clicking | | |
| Any intervention for the above - elaborate | | |
| Sleeping | | |
| Hours and times | | |
| Position | | |
| Device shut down time | | |
| Night time water intake | | |
| Mouth open / closed | | |
| Tongue visible | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Snoring | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Pauses / breaks in breathing | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Drooling during sleep | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Excess sweating | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Restless / agitated sleep | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Frequent waking | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Wakes tired | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Nightmares / night terrors | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Black rings under eyes | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

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; however, we suggest that to open lines of communication between the professionals only benefits the child being assessed.

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.

In compliance with the **Protection of Private Information Act 4 of 2013 (POPIA)**, the quantitative and qualitative results of this assessment, and/or this written assessment report, will be shared with persons on the assessment team and the designated manager who oversees the work of the assessing team. Thereafter, it will only be shared with third parties via the parents/legal guardians of the child, on their written instruction. The raw data and associated documents submitted by the parents will be secured as physical and electronic archives of Bellavista and kept for five years from the year of assessment. The test scores and a copy of this report will be secured in the electronic archives of Bellavista and kept until the child is twenty-one (21) years of age, whereafter the files will be deleted by the Information Officer at the school, or their delegate.

You are hereby informed of the [Privacy Policy](#) of Bellavista and give written consent for the administration of the assessment battery described below and the write up of this report. Further, you are invited to attend and may invite parties you prefer to attend, a discussion around the findings. Notes from these discussions will be shredded or deleted on finalisation of this report. In line with POPIA, no personally identifiable client information is shared with third-party Artificial Intelligence tools. Where limited AI functions, such as grammar or formatting assistance, are applied, these are used only on de-identified draft text and never on raw test data, personal identifiers or sensitive clinical material.

Unless estranged and there is evidence (please provide) that one of the parents does not need to sign consent, both parents must sign below.

- 1) I/we hereby authorise the release of any information with regard to _____
(full name and surname of child).
- 2) I/we hereby declare that all the information provided is accurate and true.

| | |
|--------------------------------|--|
| SIGNED: _____ | in the capacity of parent or guardian. |
| PARENT FULL NAME: _____ | DATE: _____ |
| SIGNED: _____ | in the capacity of parent or guardian. |
| PARENT FULL NAME: _____ | DATE: _____ |

PAYMENT REQUIREMENTS

Payment of R900.00 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 | |

Teacher Checklist

Please share with us some of your observations of the child's general learning and reading behaviours.

| Area | Characteristics / Behaviour | Yes/ No | |
|---|--|---------|----|
| General / Organisation | <ul style="list-style-type: none"> ● Does the child forget the right equipment for a task? ● Does the child process instructions slowly/one at a time? ● Does the child have concentration difficulties? ● Does the child struggle to carry out tasks in order? ● Does the child struggle to remember concepts from one lesson to the next? | Yes | No |
| Listening and Speaking | <ul style="list-style-type: none"> ● Does the child listen well? ● Does the child participate in oral discussion? ● Is oral language stronger than written language? | Yes | No |
| Literacy / Reading | <ul style="list-style-type: none"> ● Does the child dislike reading? ● Does the child lose his/her place frequently? ● Does the child have poor letter-sound correspondence? ● Does the child confuse words that look similar? ● Does the child confuse letter position (e.g. was/saw)? ● Does the child reverse/inverts letters (e.g. b/d, n/u)? ● Does the child leave out words? ● Does the child sound out words, making reading slow? | Yes | No |
| Written Output | <ul style="list-style-type: none"> ● Does the child struggle to sequence work? ● Does the child have good ideas, but can't write it down? ● Are there many crossings out? ● Is the child's written work incomplete? ● Does the child write slowly? ● Does the child have poor handwriting? ● Does the child reverse/inverse letters (b/d, m/w, p/q)? ● Is the writing poorly spaced? ● Does spelling show poor sound-symbol correspondence? | Yes | No |
| Mathematics/ Numeracy | <ul style="list-style-type: none"> ● Does the child have difficulties in mental math work? ● Is there a problem remembering math times tables? ● Does the child confuse/reverse numbers (e.g. 6/9, 3/5)? ● Do reading difficulties hinder understanding of questions? | Yes | No |
| Attitude to learning / tasks | <ul style="list-style-type: none"> ● Does the child prefer oral work more than reading/writing? ● Does the child have low self-esteem re schoolwork? ● Has the child developed behaviour: clown/ withdrawn? ● Does the child copy from others instead of trying? ● Is the child tired often because of extra effort? ● Does the child perform unevenly from day to day? | Yes | No |
| Identify specific difficulties and average / high ability / knowledge / skills not mentioned above that the child may experience in the classroom | Identify specific difficulties not mentioned above that the child may experience in the classroom | | |

Adapted from: Phillips, Kelly and Symes (2013: 49 – 50)