Assessment services
Parent/carer comprehensive questionnaire

Solasta
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This form is for completion by parents/guardians/carers of children referred for comprehensive developmental assessments to assist in gathering relevant family and developmental history and information regarding the presenting concerns. This information is important in assisting with planning the most appropriate assessment and the interpretation of results.

Child's details

Surname:		First names:	
Date of birth:		Age:	
Gender:	○ Male ○ Female ○ Other	Preferred pronoun:	
Country of birth:		Aboriginal or Torres Strait Islander:	○ Yes ○ No
Language(s) spoken:		Interpreter required:	○ Yes ○ No
Address:			
School attended:			
Year level:			
Current concerns e.g. nature and duration of concerns, who is concerned etc.			
Who referred your child? E.g. Friend, Teacher, Medical Practitioner			
Do you have a Paediatric referral under Medicare item code 110-131:	○ Yes ○ No		

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Parent/carer details

Parent/carer 1

Name:		Relationship to child:	
Age:		Occupation:	
Country of birth:		Aboriginal or Torres Strait Islander:	☐ Yes ☐ No
Language(s) spoken:		Interpreter required:	☐ Yes ☐ No
Address:			
Contact number/s:		Email:	

Parent/carer 2

Name:		Relationship to child:	
Age:		Occupation:	
Country of birth:		Aboriginal or Torres Strait Islander:	☐ Yes ☐ No
Language(s) spoken:		Interpreter required:	☐ Yes ☐ No
Address:			
Contact number/s:		Email:	

Are both parents and/or legal guardians aware of and consenting to the assessment:	☐ Yes ☐ No If 'No' please contact us for a discussion prior to your appointment or it may not be able to proceed.		
Name:			
Signature:		Date:	

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Family background

Father (name, age, occupation, if not stated above):	
Mother (name, age and occupation, if not stated above):	
Sibling (names and ages):	
Is there any family history of intellectual disability, autism spectrum disorder, language delay, medical conditions etc.?	

Pregnancy and birth

Pregnancy complications (If so specify)	○ No ○ Yes, please specify:		
Medication / Cigarettes / Alcohol during pregnancy (if so specify)	○ No ○ Yes, please specify:		
Birth weight:		Hospital:	
Premature / term /overdue:		Normal / caesarean / forceps delivery:	
Complications during delivery / problems identified:			

Developmental history

Milestones

First sat at:		First crawled at:	
First walked at:		Spoke first word at:	
Put two words together at:		Toilet trained (daytime) at:	
Dry at night at:			

Comments:	

Motor skills

Problems or clumsiness with – please answer yes or no to the following questions:					
Walking:	○ Yes	○ No	Running:	○ Yes	○ No
Hopping:	○ Yes	○ No	Jumping:	○ Yes	○ No
Galloping:	○ Yes	○ No	Skipping:	○ Yes	○ No
Climbing:	○ Yes	○ No	Pedalling a bike:	○ Yes	○ No
Problems with balance – please answer yes or no to the following questions:					
Balance beam:	○ Yes	○ No	Standing on one leg:	○ Yes	○ No
Problems with fine motor skills – please answer yes or no to the following questions:					
Holding a pencil:	○ Yes	○ No	Cutting with scissors:	○ Yes	○ No
Doing up buttons:	○ Yes	○ No	Using cutlery:	○ Yes	○ No
Handedness:	○ Left	○ Right	○ Mix Handedness		
Comments:					

Cognitive

Please answer yes or no to the following questions:					
Problems with attention:	○ Yes	○ No	Problems with problem solving:	○ Yes	○ No
Concerns about learning ability:	○ Yes	○ No			
Comments:					

Communication

Enjoyed two-way interaction as an infant:	○ Yes ○ No	Looks where you point:	○ Yes ○ No
Uses appropriate facial expressions:	○ Yes ○ No	Reads facial expressions:	○ Yes ○ No
Understands what is said to them:	○ Yes ○ No	Uses gesture (e.g. pointing or mimicking to indicate wants:	○ Yes ○ No
Describe your child's eye contact:			

For a verbal child, does your child use words to (please answer yes or no to the following questions)			
Ask questions:	○ Yes ○ No	Agree / refuse:	○ Yes ○ No
Make comments:	○ Yes ○ No	Describe events:	○ Yes ○ No
Express feelings:	○ Yes ○ No	Initiate and/or sustain conversation:	○ Yes ○ No
Echo what is said (directly or later):	○ Yes ○ No		
Comments:			

Areas of difficulty (please answer yes or no to the following questions)			
Grammar (use of 'ing'' "ed" etc.:	○ Yes ○ No	Interpreting language literally:	○ Yes ○ No
Understanding jokes, idioms, sarcasm:	○ Yes ○ No	Getting the order of words correct in long sentences:	○ Yes ○ No
Indulging in lengthy monologues:	○ Yes ○ No	Answering questions and responding to directions:	○ Yes ○ No
Speed / volume of voice:	○ Yes ○ No	Talking too much / too little:	○ Yes ○ No
Is speech easy to understand:	○ Yes ○ No		
Comments:			

Daily living skills

Feeding

Problems with sucking or swallowing as an infant:	○ Yes ○ No	Problems with introducing solids:	○ Yes ○ No
Present problems with chewing or swallowing:	○ Yes ○ No	Fussy eater:	○ Yes ○ No
Problems with eating outside the home:	○ Yes ○ No		
Comments:			

Dressing

Totally dependent with dressing:	○ Yes ○ No	Needs assistance with dressing:	○ Yes ○ No
Totally independent with dressing:	○ Yes ○ No	Aware of fashion trends:	○ Yes ○ No
Problems with seasonal change of clothing and shoes:	○ Yes ○ No		
Comments:			

Toileting

Daytime bladder control at what age:		Night time bladder control at what age:	
Bowel control at what age:		Any current toileting issues:	
Comments:			

Sleep

Child's sleep pattern in first 12 months:	
Particular routines to settle to sleep as a baby:	
Particular routines required to settle to sleep now:	

Current sleep habits

Hours:		Location:	
Wakes at night:		Current or previous use of medication to sleep:	
Problems sleeping away from home:			
Comments:			

Medical history

Past and current medical history

Illnesses and conditions:		Serious injuries and accidents:	
Operations and hospitalisations:		Medication:	
Allergies:		Is your child fully immunised:	○ Yes ○ No
Hearing check (when, where and result):			
Vision check (when, where and result):			

Investigations (blood tests, CT scans, MRI, EEG):	
Previous therapy and intervention:	
Current therapy and intervention:	
Do you receive a carer's allowance for this child:	☐ Yes ☐ No
Comments:	

Social

< 3 years old

Before the age of three did / does your child (please mark those that apply):	
☐ Make eye contact with people	☐ Respond to voices, movement of people
☐ Initiate peek-a-boo games	☐ Anticipate being picked up (arms up)
☐ Show awareness of and interest in other children	☐ Show imaginative abilities in play
☐ Greet and wave goodbye	☐ Bring books to you to read a story
☐ Imitate activities/actions of other children, adults, TV	☐ Initiate social interactions
☐ Invite others to play	☐ Ask for help
☐ Gain joint attention by pointing, looking and talking	☐ Let others know they are sick or hurt
Comments:	

3 years old

Does your child have regular opportunity to interact with other children:	☐ Yes ☐ No
Does your child (please mark those that apply):	
☐ interact well with same age children	☐ hold social chat
☐ invite other children to come home to play	☐ share and take turns to play
☐ get invited to other children's homes to play	☐ compliment others

☐ know how to make friends and have close friends	☐ ask for feedback
☐ offer/accept help/comfort	☐ share other's enjoyment
☐ understand the consequences of their actions	☐ over-react to criticism / teasing

Comments:	

School aged

Does your child have problems with (please mark those that apply):	
☐ showing empathy towards others	☐ aggression towards others
Does your child (please mark those that apply):	
☐ approach and talk to strangers	☐ make inappropriate comments in public
☐ respect other people's privacy	☐ accept some things aren't possible

Comments:	

Emotions and behaviour

Was your child difficult to console as an infant:	○ Yes ○ No

Describe your child's usual response when upset (please mark those that apply):		
☐ tears	☐ screams	☐ whines
☐ temper tantrum	☐ odd language	☐ aggressive
☐ verbally abusive	☐ isolates themselves	☐ seeks consolation
☐ no emotion		

Carer usually knows the cause of upsets:	○ Yes ○ No

Gets upset when people break other's rules of THEIR rules:	☐ Yes ☐ No	Mood swings:	☐ Yes ☐ No
Inappropriate giggling or laughing:	☐ Yes ☐ No	Strong fears of phobias:	☐ Yes ☐ No
Child aware of/and learns from danger e.g. burns:	☐ Yes ☐ No	Poor confidence/ self-esteem:	☐ Yes ☐ No
Regular tantrums:	☐ Yes ☐ No	Are these behaviours a problem:	☐ At home ☐ At school
Comments:			

Play / specific interests

Plays appropriately with toys:	☐ Yes ☐ No	Obsessed with parts of objects:	☐ Yes ☐ No
Specifically (please mark those that apply):			
☐ spinning wheels ☐ mouthing ☐ fiddling with strings or ribbons ☐ other (please specify)			
Spends long periods playing alone:	☐ Yes ☐ No	Obsession to the point of occupying child's time exclusively:	☐ Yes ☐ No
Specifically (please mark those that apply):			
☐ collection of objects ☐ particular topic of conversation ☐ TV program ☐ special video ☐ lining up objects ☐ other (please specify)			
Comments:			

Rigid routines and rituals

Any rigid non-functional routines around sleep, mealtimes, dressing, play or other activities:	○ Yes ○ No
Comments:	

Change

Problem with separation:	○ Yes ○ No	Problem with change of teacher at kindy or school:	○ Yes ○ No
Problem with change in familial routine:	○ Yes ○ No	Problem with holidays, moving house, start or change of kindy or school:	○ Yes ○ No
Rigid way of doing things:	○ Yes ○ No	Difficult to shift from one activity to the other e.g. going out, during play:	○ Yes ○ No
Comments:			

Repetitive behaviour

Repetitive self-stimulatory behaviours:	○ Yes ○ No
Specifically (please mark those that apply):	
☐ hand flapping ☐ facial grimacing ☐ toe walking ☐ self-harming behaviour ☐ other (please specify)	
Comments:	

Sensory responses

Arousal level/sensory seeking behaviour:	○ Yes ○ No
Specifically (please mark those that apply):	
☐ always on the go ☐ fidgety ☐ restless ☐ disorganised behaviour ☐ lethargic/tired	
Comments:	

Touch

Over-reacts to touch:	○ Yes ○ No
Does your child (please mark those that apply):	
☐ not snuggle when cuddled ☐ dislike sticky hands/face ☐ dislike certain clothing/tags ☐ dislike showers ☐ prefer deep to light touch ☐ under-react to pain	☐ refuse to touch certain things ☐ refuse to go barefoot ☐ resist hair brushing and nail cutting ☐ over-react to plain ☐ become irritated if touched or bumped ☐ get too close to others
Is your child (please mark those that apply):	
☐ heavy handed ☐ prone to bumping into things	☐ rough with others
Comments:	

Sound

Does your child (please mark those that apply):	
☐ become overwhelmed by household noises such as vacuum cleaner, lawn mower, food blender	
☐ have difficulty coping with noisy environment such as a busy shopping centre	
☐ become distracted by background noises such as clock ticking, ventilation humming	
☐ other (please specify)	
Does your child (please mark those that apply):	
☐ act as if deaf at times	☐ not respond to name call or instructions
☐ seem oblivious to unexpected noises	☐ other (please specify)
Comments:	

Smell

Does your child (please mark those that apply):	
☐ react strongly to some smells	☐ Smell non-food objects such as people's hair
☐ ignore strong odours	
Comments:	

Taste

Does your child (please mark those that apply):	
☐ lick things	☐ eat non edibles
Comments:	

Vision

Is/does your child (please mark those that apply):	
☐ sensitive to light ☐ look at things in an unusual way e.g. peripheral vision, examine things closely ☐ fixate on patterns, lights, lines, spinning wheels, mirrors	
Comments:	
How much are your child's sensory difficulties impact on their day to day living:	

Present services

Name of childcare:		Planned kindy/school and entry date:	
Name of kindy/school (where, what year):		Name of teacher:	
Education support:		Negotiated Education Plan (NEP):	
Speech Therapy (who, how often):		Physiotherapy (who, how often):	
Psychology (who, how often):		Paediatrician (who and date of last appointment):	
General Practitioner (who):		Other agencies involved: e.g. Inclusive Directions, Disability SA, CAMHS, Community Health.	
Comments:			

Strengths and assets

Child's strengths, interests and hobbies:	

Parental expectations and hopes from the assessment

Comments:	

Thank you for completing the questionnaire. The information you have provided will assist greatly with this assessment.

Please e-mail completed form to **info@solasta.net.au** or fax to **(08) 7160 1999**.