

Assessment services

Parent/carer comprehensive questionnaire



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

First names		Surname	
Date of birth:		Age:	
Gender:	<input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Other	Preferred pronoun:	
Country of birth:		Aboriginal or Torres Strait Islander:	<input type="radio"/> Yes <input type="radio"/> No
Language(s) spoken:		Interpreter required:	<input type="radio"/> Yes <input type="radio"/> No
Address:			

Parent/carer details

Parent/carer 1

Name:		Relationship to child:	
Age:		Occupation:	
Country of birth:		Aboriginal or Torres Strait Islander:	<input type="radio"/> Yes <input type="radio"/> No
Language(s) spoken:		Interpreter required:	<input type="radio"/> Yes <input type="radio"/> No
Address:			
Contact number/s:		Email:	

Parent/carer 2

Name:		Relationship to child:	
Age:		Occupation:	

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Country of birth:		Aboriginal or Torres Strait Islander:	<input type="radio"/> Yes <input type="radio"/> No
Language(s) spoken:		Interpreter required:	<input type="radio"/> Yes <input type="radio"/> No
Address:			
Contact number/s:		Email:	

Are both parents and/or legal guardians aware of and consenting to the assessment:	<input type="radio"/> Yes <input type="radio"/> No If 'No' please contact us for a discussion prior to your appointment or it may not be able to proceed.		
Are there any court orders in place?	<input type="radio"/> Yes <input type="radio"/> No If Yes please provide a copy		
Name:			
Signature:		Date:	

Reason for Referral

What are your main concerns about your child's development/behaviour? Who has raised these concerns, and how long have they been present?	
Who referred your child or suggested an assessment (e.g., medical practitioner, friend, teacher, allied health professional)	
What are your expectations and hopes from this assessment?	
Do you have a Paediatric referral under Medicare item code 110-131:	<input type="radio"/> Yes <input type="radio"/> No

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Family background

Father (name, age, occupation, if not stated above):	
Mother (name, age and occupation, if not stated above):	
Siblings (names and ages):	
Who lives in the household with the child? If they live in multiple households, please specify the care arrangement.	
Is there any family history of intellectual disability, autism spectrum disorder, language delay, medical conditions etc?	

Pregnancy and birth

Pregnancy complications	<input type="radio"/> No <input type="radio"/> Yes, please specify:		
Medication / Cigarettes / Alcohol during pregnancy	<input type="radio"/> No <input type="radio"/> Yes, please specify:		
Birth weight:		Hospital:	
Premature / term /overdue:		How was your child delivered:	<input type="radio"/> Vaginal delivery <input type="radio"/> Assisted vaginal delivery (e.g. forceps or ventouse) <input type="radio"/> Planned caesarean section <input type="radio"/> Emergency caesarean section

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<p>Complications during delivery / problems identified:</p>	
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Medical history

Past and current medical history

Diagnosed illnesses and conditions			
Results of any Medical Investigations (blood tests, CT scans, MRI EEG etc)			
Serious injuries and accidents:			
Operations and hospitalisations:			
Allergies:			
Current Medications:		Is your child fully immunised:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the child's vision been checked?	<input type="checkbox"/> Yes <input type="checkbox"/> No Date of test and any issues identified:		
Has the child's hearing been checked?	<input type="checkbox"/> Yes <input type="checkbox"/> No Date of test and any issues identified:		
Do you receive a carer's allowance for this child:	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Additional information			

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:		Any current toileting issues?	

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Comments:	
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Psychosocial/ Early Life Experiences

Please indicate if your child has experienced any of the following life experiences and provide brief details if yes:

Parental separation/divorce		Death of a loved one	
Exposure to family violence		Child protection involvement	
Parental mental health concerns		Housing instability	
Significant bullying or social exclusion		Any other significant events	
Please provide details:			

Current Functioning

Motor skills

Please describe your child's:

Physical coordination skills, including any difficulties walking, running, climbing, riding a bike etc	
Fine motor skills, including any difficulties using cutlery, pencil, grip, doing up buttons etc	
Handedness (left, right, mixed-handed?)	

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Cognition and Learning

Current school/preschool		Year Level	
Teacher Name and Email contact			
Please list any previous schools attended and dates.			
Please describe your child's academic skills, including areas of strength and areas of concern:			
Please provide details of current/previous school supports (e.g. ESO support, small group literacy or numeracy programs):			
Please describe any concerns regarding social issues or behaviour at school (including any issues with attendance).			
Concerns reported from school:			

Daily Living Skills

Please describe any concerns regarding feeding and eating (e.g., issues chewing and swallowing, fussy eating/limited diet, difficulties eating outside the home)	
Can your child dress themselves independently? If not, what kind of assistance do they need?	

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Does your child have difficulties with seasonal changes in clothing and shoes? Any issues with particular types of clothing?	
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Sleep habits

Typical Sleep Hours and pattern:		Typical sleep Location:	
Do they wake at night?		Current or previous use of medication to sleep:	
Any problems sleeping away from home:			
Particular routines required to settle to sleep (current and past):			
Comments:			

Strengths and Interests

Describe your child's strengths	
Describe your child's interests/hobbies	

Social Skills

Communication Skills

How does your child initiate interactions and conversation with others?	
What do they do when other people approach them to interact?	

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Do they share their interests with others? How do they do this? (e.g., showing/telling them)	
How would you describe their conversational skills (e.g., back-and-forth conversations, only talking about their interests, talking about a range of topics)	
Do they show an understanding of how others are feeling/offer comfort to others? If so, how?	
Is your child able to read social cues and understand the intentions of others? Describe any concerns	
Do they use gestures to communicate (e.g., pointing, waving)?	
How would you describe their use of eye contact?	
How well do they understand others' nonverbal cues (e.g., facial expressions body language)?	
How well do their facial expressions match their emotions?	

Friendships and Relationships

Does your child show an interest in interacting with peers? If so, how do they initiate this?	
How do they interact in group settings?	

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How well do they make and maintain friendships?	
Do they engage in imaginative play with others? If so, what do they play? For older children, did they engage in imaginative play when younger?	

Emotions and behaviour

Emotional Regulation

Was your child difficult to console as an infant:	<input type="radio"/> Yes <input type="radio"/> No
Describe your child's usual response when upset (please mark those that apply):	
<input type="checkbox"/> tears <input type="checkbox"/> screams <input type="checkbox"/> whines <input type="checkbox"/> temper tantrum <input type="checkbox"/> odd language <input type="checkbox"/> aggressive <input type="checkbox"/> verbally abusive <input type="checkbox"/> isolates themselves <input type="checkbox"/> seeks consolation <input type="checkbox"/> no emotion	
Carer usually knows the cause of upsets:	<input type="radio"/> Yes <input type="radio"/> No
Describe any challenges with regulating emotions	

Repetitive Behaviour

Does your child flap their hands, rock, spin objects, walk on their toes or repeat certain movements? Did they do this when younger?	
Do they line up toys or engage in any other repetitive play? Did they do this when younger?	

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<p>Do they repeat what has just been said (by themselves or others) or repeatedly use particular words or phrases (e.g., lines from TV/videos)?</p>	
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Predictability and Routine

<p>Does your child become distressed by changes in their routine or environment?</p>	
<p>Do they have any particular rituals or routines they need to follow? What happens if they are unable to perform these routines?</p>	
<p>Do they have difficulty moving from one activity or place to another?</p>	

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Strong Interests

Does your child have any strong or unusual interests? Did they when they were younger?	
What do they do when they have a strong interest in something?	
How much time do they spend engaged in these interests? Does it get in the way of them doing other things?	

Sensory responses

Arousal level/sensory seeking behaviour:	<input type="radio"/> Yes <input type="radio"/> No
Specifically (please mark those that apply):	
<input type="checkbox"/> always on the go <input type="checkbox"/> disorganised behaviour <input type="checkbox"/> fidgety <input type="checkbox"/> lethargic/tired <input type="checkbox"/> restless	
Details:	

Touch

Over-reacts to touch:	<input type="radio"/> Yes <input type="radio"/> No
Does your child (please mark those that apply):	
<input type="checkbox"/> not snuggle when cuddled <input type="checkbox"/> refuse to touch certain things <input type="checkbox"/> dislike sticky hands/face <input type="checkbox"/> refuse to go barefoot	

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<input type="checkbox"/> dislike certain clothing/tags	<input type="checkbox"/> resist hair brushing and nail cutting
<input type="checkbox"/> dislike showers	<input type="checkbox"/> over-react to plain
<input type="checkbox"/> prefer deep to light touch	<input type="checkbox"/> become irritated if touched/ bumped
<input type="checkbox"/> under-react to pain	<input type="checkbox"/> get too close to others
Is your child (please mark those that apply):	
<input type="checkbox"/> heavy handed	<input type="checkbox"/> rough with others
<input type="checkbox"/> prone to bumping into things	
Details:	

Sound

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

Smell

Does your child (please mark those that apply):	
<input type="checkbox"/> react strongly to some smells	
<input type="checkbox"/> Smell non-food objects such as people's hair	
<input type="checkbox"/> ignore strong odours	

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Details:	
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Taste

Does your child (please mark those that apply):	
<input type="checkbox"/> lick things <input type="checkbox"/> eat non edibles <input type="checkbox"/> mouth/chew things <input type="checkbox"/> have a restricted diet	
Comments:	

Vision

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

Other

Is/does your child (please mark those that apply):	
<input type="checkbox"/> Know when they are hungry or thirsty <input type="checkbox"/> When eating/drinking do they know when they are full? <input type="checkbox"/> Do they recognise when they are hot or cold?	

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Details:	
How much do your child's sensory difficulties impact on their day to day living:	

Past and present services

Please also attach any previous letters or reports

Name of childcare:		Planned kindy/school and entry date:	
General Practitioner (who):		Paediatrician (who and date of last appointment):	
Other agencies involved: e.g. Inclusive Directions, Disability SA, CAMHS, Community Health.			
Allied Health (e.g., OT, Speech Therapy, Psychology)			
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 **1800 943 043**.