**Trafford Children’s Therapy Service**

**PRESCHOOL – MOTORSKILLS QUESTIONNAIRE FOR PARENTS**

**Name & Designation of Medical Referrer**:

**Please note that the referral will not be progressed to appointment unless the parent questionnaire is received within 4 weeks of medical appointment.**

Date of questionnaire completion:

Child’s Name:

DOB:

Age:

Address: ­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Post Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Tel No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School/Nursery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Named Keyworker: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tel No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GP Name and Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/carers full name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have a social worker? Yes / No. If yes, please give details below.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tel No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please give the name and ages of any brothers and sisters
2. Please give a brief history, below are some points to prompt you e.g. weeks gestation, type of delivery, any complications, special care baby unit, low birth weight, feeding difficulties
3. Give details of past medical history and any current medical problems e.g. vision, hearing, glue ear, recurrent infections, speech difficulties, hospital admissions, and current mediation
4. Please give approximately ages your child achieved these milestones

Sitting ………………………………

Crawling ………………………………

Standing ………………………………

Walking ………………………………

1. Is your child developing any independence skills with dressing?
2. When sat at the table to eat his / her dinner does your child have any difficulties with the following: -

|  |  |
| --- | --- |
| Stabbing food with a fork |  |
| Controlling the cutlery to cut food, stab food |  |
| Taking the food to his / her mouth |  |
| Drinking from a cup |  |
| Sucking through a straw |  |
| Controlling food once in the mouth |  |
| Staying on the chair and / or at the table |  |

1. Does your child have difficulty with any of the following?

Climbing up and down stairs (one foot per step) Yes / No

Walking at a quick pace for 10 minutes Yes / No

Stepping on / off pavement Yes / No

Negotiating his / her way past other pedestrians on a

busy street or playground Yes / No

Using equipment in the park or soft play centre Yes / No

Pedalling a tricycle Yes / No

Please comment on any of the above, if appropriate.

1. What are your child’s interests?
2. Can your child: -

Throw a ball Yes /No

Catch a ball Yes / No

Kick a ball Yes /No

Drop a ball Yes / No

Bounce a ball Yes /No

10 Does your child avoid any activities?

11 Do you feel that your child has improved skills with practise?

12 What do you feel your child’s main strengths are?

13 What are your child’s main difficulties, which cause you most concern?

14 Any other comments?