Wirral University Teaching Hospital NHS Foundation Trust

WIRRAL CHILDREN'S OCCUPATIONAL THERAPY SERVICE

PARENT QUESTIONNAIRE
For CHILDREN with MOTOR CO-ORDINATION DIFFICULTIES

Child's name	
Date of Birth	
Home Address Mobile Number Home Tel No	
Parent/Guardian email address	
GP name & address	
Name of parent/guardian	
School	

PLEASE COMPLETE THIS FORM IN BLACK INK BY FILLING IN OR CIRCLING AS APPROPRIATE.
PLEASE PRINT.

DEVELOPMENTAL HISTORY

Was your child delayed in reaching any of the following developmental milestones:-		
	Sitting unsupported	YES / NO
	Crawling	YES / NO
	Walking	YES / NO
	Talking	YES / NO
Has your child had a sight test?		YES / NO
Difficulties identified……		
Has your child had a hearing test?		YES / NO
Difficulties identified……		
Which hand does your child use to write with?		RIGHT / LEFT
Has your child been assessed by	Physiotherapist	YES / NO
	Speech & Language Therapist	YES / NO
	Educational Psychologist	YES / NO
	Child & Family Service	YES / NO
Other professionals involved (please state)……..		
……		

Is your child experiencing any difficulties in school? If yes, in which areas……..	YES /NO
……	
……	

SAFETY

Do you consider there are any safety issues within the home (including stairs, bathroom, kitchen), car, school transport or outside environment?

PERSONAL CARE

Does your child have difficulty undressing?	YES / NO	
Does your child have difficulty dressing?	YES / NO	
Does your child have difficulty fastening buttons?	YES / NO	
Does your child have difficulty tying shoe laces?	YES / NO	
Does your child have difficulty organising clothes (ie. does he/she put them on back to front, inside-out)?	YES / NO	
Does your child have difficulty understanding which order to put the clothes on?	YES / NO	
Does your child have difficulty managing cutlery?	YES / NO	
Is your child messy when eating?	YES / NO	
Does your child frequently spill / knock drinks over?	YES / NO	
Does your child have difficulty brushing their teeth?	YES / NO	
Does your child have difficulty wiping their bottom?	YES / NO	

CO-ORDINATION SKILLS

Does your child fall over more frequently than his peers?	YES / NO	
Does your child frequently bump into doorways or people?	YES / NO	
Does your child have difficulty riding a bicycle?	YES / NO	
Does your child need stabilisers in order to ride a bicycle?	YES / NO	
Has your child had frequent practice learning to ride a bicycle?	YES / NO	

CHILD'S NAME……DOB……..

CO-ORDINATION SKILLS (continued)

Does your child have difficulty swimming?	YES / NO	
Does your child need a swimming aid e.g. float or armbands?	YES / NO	
Has your child had regular swimming practice / lessons?	YES / NO	
Does your child have difficulty standing on one leg?	YES / NO	
Does your child have difficulty jumping?	YES / NO	
Does your child have difficulty hopping?	YES / NO	
Does your child have difficulty catching a ball?	YES / NO	

SOCIAL / EMOTIONAL / BEHAVIOURAL DEVELOPMENT

Which would you say describes your child? (tick as appropriate)

☐ Quiet	☐ Shy	☐ Overestimates abilities
☐ Overactive	☐ Behaviour problems	☐ Reluctant to try new things
☐ Upset by failure	☐ Confident	☐ Fidgety
☐ Lacking in self confidence	☐ Sociable	☐ Fear of heights
☐ Impulsive	☐ Underestimates own ability	☐ Reacts to loud noises
☐ Lacking safety awareness	☐ Emotional	☐ Reacts to teeth/hair being brushed
☐ Low self esteem	☐ Aggressive	
☐ Withdrawn	☐ Temper tantrums	☐ Reacts to different textured of clothing
☐ Anxious	☐ Poor concentration	☐ Does not like messy play

If there is any other information which you feel may be useful please give details

In your opinion, what do you consider to be your child's main motor skill difficulties at present?
1. 2. 3.

What does your child consider his/her main difficulties to be?
1. 2. 3.

1. Do you give consent for the OT service to contact any other relevant professionals involved in your child's care in order to gather further information about his/her difficulties?	YES / NO
2. Do you give consent for the therapist to give verbal feedback of the results of the assessment in front of your child? This is done as sensitively as possible but is likely to involve statements about the difficulties your child is experiencing and where they are in relation to other children of the same age. If you do not wish the child to be present during the feedback, please ensure that you bring another adult with you who can wait with the child outside of the clinic room	YES / NO

Signed……Parent/guardian/carer Date…….

Please return completed form to:

Wirral Children's Occupational Therapy DCD Team
Cherry Tree House
Clatterbridge Hospital
Bebington
CH63 4JY

Or alternatively, scan or photograph and e-mail a copy to:

wuth.sensorymotorteam@nhs.net