**Client Questionnaire for Children**

**Please complete this form, and let me know if you have any questions, or would prefer to complete this during meetings. If a section is not applicable, leave it blank.**

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| Parent Names: |  |
| Name of child: |  |
| DOB: |  |
| Today’s Date: |  |
| Address: |  |
| Mobile numbers: |  |
| Email addresses: |  |

**Past/current Education and Therapy**

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| --- | --- | --- |
| Name of therapist/centre/school | Type of therapy/education | Duration |
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**Please tell us about your child’s interests including favorite toys, videos, games, places to visit (museums, playgrounds), activities.**

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**List 3 priorities that you would like to work on during our time together.**

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| 1- |
| 2- |
| 3- |

**Environmental assessments**

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| **Home** | **School** |
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**Autism Diagnosis**

When was your child diagnosed with autism?

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How was the diagnosis made and what was the duration?

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**Describe your child’s gross motor skills**.

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| Riding a bike |  |
| Running |  |
| Walking |  |
| Climbing |  |
| Stair climbing |  |

**Describe your child’s fine motor skills:**

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| --- | --- |
| Writing |  |
| Handling small objects/toys |  |
| Feeding/small pieces of food |  |
| Drawing/coloring |  |

Which hand does your child use for: Writing/drawing? \_\_\_\_\_\_\_\_\_ Eating? \_\_\_\_\_\_\_\_ Cutting?\_\_\_\_\_\_\_\_\_\_

Current eating behavior: Normal  Picky  Eats too much  Weight loss/gain

Oral Motor concerns: None  Difficulty swallowing Drooling Gagging

**Adaptive Skills:**

Feeds self  No Yes, beginning at age \_\_\_\_\_\_\_

Dresses self  No Yes, beginning at age \_\_\_\_\_\_\_

Bathes self  No Yes, beginning at age \_\_\_\_\_\_\_

Helps with household chores  No Yes, beginning at age \_\_\_\_\_\_\_

Knows first and last name  No Yes, beginning at age \_\_\_\_\_\_\_

Says “please” and “thank you”  No Yes, beginning at age \_\_\_\_\_\_\_

Has the child ever lost skills, which at one time he/she was able to perform?  Yes  No

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Behavior**

Is there anything you would like to discuss regarding your child’s behavior?

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Describe your child’s interactions with their peers.

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Describe your child’s relationship with siblings.

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Does (did) your child have any problems learning letters/numbers? Please explain.

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Does he/she confuse the sounds in words when speaking?

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Describe his/her handwriting/fine motor skills when drawing, writing or playing with small objects.

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Can your child follow one step directions? Two step directions? Please explain with examples.

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Does your child use vocabulary that is age-appropriate?

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**Does your child…**

1. Cuddle like other children: Yes No

2. Look at you when you are talking or playing? Yes No

3. Smile in response to a smile from others? Yes No

4. Engage in reciprocal, back-and-forth play? Yes No

5. Play simple imitation games, such as pat-a-cake or peek-a boo? Yes No

6. Show interest in others? Yes No

7. Point with his or her finger? Yes No

8. Gesture (e.g., nod yes and no)? Yes No

9. Direct your attention by holding up objects for you to see? Yes No

10. Show things to people? Yes No

11. Give inconsistent response to his or her name (or to commands)? Yes No

12. Use rote, repetitive, or echolalic speech? Yes No

13. Have repetitive behavior? Yes No

14. Have preoccupations or a narrow range of interests? Yes No

15. Have limited or absent pretend play? Yes No

16. Play with toys in the same exact way every time? Yes No

17. Appear strongly attached to a specific unusual object(s)? Yes No

**Does your child seem sensitive to….**

1. Touch (tags, clothing, touch by others)? Yes No

2. Noise (puts hands over hears, becomes very distracted)? Yes No

3. Foods (textures, tastes, temperatures)? Yes No

4. Smells (highly sensitive to faint smells or smells objects)? Yes No

5. Movement (does not like swings, somersaults, etc.)? Yes No

6. Changes in routine (transitioning, becomes upset)? Yes No

7. Activity (tires easily, props self when playing/sitting)? Yes No

**Additional notes:**

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