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 **ACACIA THERAPY INTAKE QUESTIONNAIRE**

Please find below a short referral form to complete to help us prepare for your initial session by finding out a little bit more about you, your child and your family.

**SECTION A**

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| ***Child details:*** |
| First name/s: |   | Surname: |   |
| Date of Birth:  |   /   / | Gender:  |   |
| Address:  |   | Year level *(if applicable)* |   |
| Current school/ Kindergarten / Day Care  |   | Teacher:  |   |
| Country of Birth: |   | Language/s spoken: |   |
| Does your child identify as:   | Aboriginal/ Torres Strait Islander / Non-indigenous / Other |
| **NDIS information (if applicable)**  |
| NDIS number:  |   | Plan dates:  |   |
| *Please circle:* | *NDIA managed?* | *Self managed?* | *Plan managed? Plan manager details:\_\_\_\_\_\_\_\_\_\_\_* |

|  |  |
| --- | --- |
| **Therapy Goals:** | *1)* |
| *Add goals as required* | *2)* |
| *3)* |
| *4)* |
| *5)* |
|  ***Parent/Carer details:*** |  |
| *Parent/Carer 1 (Primary)* | *Parent/Carer 2 (if applicable)* |
| Name: |   | Name: |   |
| Contact phone number: |   | Contact phone number: |   |
| Email: |   | Email: |   |

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| *About your child:* |
| Who does your child currently live with? Please include ages of siblings if applicable  |
|  |
| Has your child previously, or is currently, accessing any other services, such as a Paediatrician, Speech Pathologist, Psychologist, Physiotherapist, Occupational Therapist etc?  If so, please include details  |
| *\*Please attach any reports that you think may be relevant, or bring with you to the first session*  |
| Are there any aspects of your child’s medical history that you feel are important for us to know? |
|      |
| Thinking back to the pregnancy, birth and early development of your child, are there any details of these events that you feel are important for us to know?  |
|      |
| Has your child received a diagnosis of any disorder, disability or syndrome? If yes, please include details: |
|      |
| Is your child currently taking any regular medication?  |
|     |
| With regards to family history, are there any particular diagnoses or circumstances that you feel are important for us to know?  |
|  |
| Is there anything else about you or your family that you would like us to know before meeting you and your child?  |
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| *Reason for referral:*  |
| Please describe the main area of concern for your child and why you wish to Occupational Therapy services from Acacia Therapy:  |
|   |
|   |
|  SECTION B:  OPTIONAL - *Additional Information* *This section requests further information about your child across a variety of everyday tasks and skills.  Please note, this section is optional, and can be left blank, especially if you feel that you have shared all the relevant information in Section A, or would prefer to discuss in person.*   |
| Please provide a short comment on your child’s skills (strengths and/or difficulties) in the following areas: |
|   |
| Fine Motor Skills: (using their hands and fingers: e.g. drawing, cutting, writing, doing up zips/buttons)   |
|   |
| Gross Motor Skills: (running, jumping, skipping, climbing)  |
|   |
| Play and Social skills: (with adults and with other children; at school and/or at home)  |
|   |
| Self Help Skills: (dressing, toileting, brushing teeth)  |
|   |
| Behaviour and Concentration: (at home and in the classroom)  |
|   |
| Sensory Processing: (e.g. Differences in the way your child reacts, responds to or seeks out certain types of sensory input, such as limiting clothing or food choices, reacting to loud environments, seeking out movement or touch constantly throughout the day)   |
|   |
| Communication skills? |
|  |

Please return completed form to: info@acaciatherapy.net