The Sensory Gym
4C/28 Laurence Street
Hobartville NSW 2753
02 4578 9799

REFERRAL QUESTIONNAIRE

If you are completing this form electronically, the boxes will expand appropriately.

CONTACT AND FAMILY INFORMATION							
Child's Name:		Sex:	Date of Birth: / /				Age:
Parent(s)/Carer(s) Name(s):			Parent(s) Occupation(s):				
Parent(s)/Carer(s) Age(s):			Sibling(s) Name(s):				
Who referred you to Occupational Therapy:			Sibling(s) Age(s):				
How did you hear about The Sensory Gym:							
Address:							
City:		State:			Post Code:		
Email:							
Home Phone:		Work Phone:			Mobile Phone:		
Do you have a Medicare plan? YES☐ NO☐		If so, which one?					
Do you have a private health fund? YES☐ NO☐		If so, who is your provider?					
School Attending:					Year/Level:		
Teacher's Name:					School Phone:		
GENERAL INFORMATION							
Were there any complications, illnesses, or stress during pregnancy?	NO ☐	YES. ☐ Please comment.					
Were there any complications during labour or delivery?	NO ☐	YES. ☐ Please comment.					
Please specify the conditions of your child's birth. Indicate all that	Vaginal ☐	Forceps ☐	Vacuum ☐	C-section ☐	Premature ☐	Past due date ☐	Full-term ☐

DEVELOPMENTAL HISTORY							
Please note the approximate age when your child achieved the following skills.	Sitting	Belly crawling	Crawling	Cruising	Walking	First words	Talking
	Hopping	Jumping	Skipping	Running	Riding a tricycle	Riding a 2-wheel bike	Skipping rope
If your child has a medical diagnosis, please specify.							
Professional(s) who made the diagnosis							
Does your child have a history of ear infections?	NO ☐	YES ☐					
		How many?					
		At what ages?					
		How were they treated?					
Does your child currently take any medications?	NO ☐	YES. ☐ Please comment.					
Does your child have any allergies?	NO ☐	YES. ☐ Please comment.					
Has your child experienced any major injuries or hospitalisations?	NO ☐	YES. ☐ Please comment.					
Does your child have a history of seizures?	NO ☐	YES. ☐ Please comment.					
Does your child wear glasses?	NO ☐	YES. ☐ What are the glasses meant to correct?					
Has your child received occupational therapy services in the past?	NO ☐	YES					
		At what age did your child begin therapy?					
		How long did/has your child receive(d) therapy?					
		How frequently was/is your child seen for therapy?					
		Where were they seen for services?					

Has/does your child receive other interventions? Indicate all that apply.	NO ☐	YES ☐				
		Speech therapy ☐	Physiotherapy ☐	Applied Behavioural Analysis (ABA) ☐	DIR/ Floortime ☐	Others:
		Date Started:	Date Started:	Date Started:	Date Started:	Date Started:
		Where?	Where?	Where?	Where?	Where?
		Name of Clinician:	Name of Clinician:	Name of Clinician:	Name of Clinician:	Name of Clinician:
What are your primary concerns?						
What is/are the hardest time(s) of the day and how do these times impact on your family?						

SLEEPING								
What activities do you use as part of your child's bedtime routine? Indicate all that apply.	Bath time ☐	Singing/ Humming ☐	Reading ☐	Cuddling ☐	Bouncing ☐	Massage ☐	Rocking ☐	Others:
Please describe any necessary specifics regarding your child's bedtime routine.								

What happens if this routine is disrupted?	Impact on child:						
	Impact on family members:						
What time is your child put to bed?							
What time does your child fall asleep?							
Where does your child fall asleep?							
Does your child have difficulty with sleeping?	NO ☐	YES ☐					
		Do family members have interrupted sleep as a result?	NO ☐	YES ☐			
How many times per night does your child waken?	Almost never ☐	1-2 ☐	3-4 ☐	5-6 ☐	7+ ☐		
What does your child do when he/she awakens?	Whimper ☐	Screams ☐	Plays with toys ☐	Goes to parents' bedroom ☐	Puts self back to sleep ☐	Others:	
What activities do you use to get your child back to sleep? Indicate all that apply.	Feeding ☐	Singing ☐	Humming ☐	Cuddling ☐	Rocking ☐	Bouncing ☐	Massage ☐	Others:
Describe any routines that are helpful for getting your child back to sleep.							
How old was your child when he/she consistently slept through the night?							

Does your child seem to require too much or too little sleep or sleep at odd times?	NO ☐	YES ☐		
		How many hours nightly?		
		What times of day?		
Does your child take naps?	NO ☐	YES ☐		
		Frequency of naps?		
		Duration of naps?		
		Location of naps?		
		Does your child need help to fall asleep for nap?	NO ☐	YES ☐
What time does your child awaken?				
What mood is your child in upon awakening in the morning?				
FEEDING				
Was your child breast fed as an infant?	NO ☐	YES. ☐ For how long?		
If child was bottle fed as an infant, were there any difficulties or concerns?	NO ☐	YES. ☐ Please comment.		
Did your child have a strong suck as an infant?	NO ☐	YES ☐		
Did your child frequently spit up as an infant or have reflux?	NO ☐	YES. ☐ Please comment.		
Did your child have problems with appetite or weight gain as an infant?	NO ☐	YES. ☐ Please comment.		

Did your child respiratory problems as an infant?	NO ☐	YES. ☐ Please comment.
Does your child avoid/limit food based on the following characteristics? Indicate all that apply.	NO ☐	YES ☐ Variety of food selection ☐ | Temperature ☐ | Food texture ☐ | Crunchy foods ☐ | Chewy foods ☐ | Food colour ☐ | Mixed food textures ☐ Please comment.
Does your child show strong preferences for food based on the following characteristics? Indicate all that apply.	NO ☐	YES ☐ Variety of food selection ☐ | Temperature ☐ | Food texture ☐ | Crunchy foods ☐ | Chewy foods ☐ | Food colour ☐ | Mixed food textures ☐ Please comment.
Does your child have difficulty with ingesting foods? Indicate all that apply.	NO ☐	YES ☐ Chewing variety of foods ☐ | Sucking through a straw ☐ | Swallowing a variety of foods ☐ Please comment.
Is there a disruption in family mealtime as a result of atypical eating patterns?	NO ☐	YES. ☐ Please comment.
Does your child exhibit oral motor sensitivities or seeking? Indicate all that apply.	NO ☐	YES ☐ Examines objects by placing in mouth ☐ | Gags/vomits frequently ☐ | Bites/chews objects or clothing frequently ☐ | Grinds teeth ☐

Does your child attempt to eat unusual, noxious, or inedible substances or place in mouth?	NO ☐	YES. ☐ Please comment.

How long does your child sit at mealtime?	1-2 minutes ☐	3-5 minutes ☐	6-10 minutes ☐	Entire meal ☐
	Does this impact on the quantity of food ingested?		NO ☐	YES ☐
	How does this impact harmony at mealtimes? Please comment.			

Where does your child eat meals?	Please comment.
What routines do you follow that are helpful for getting your child to eat meals?	Please comment.
What happens if this routine is disrupted?	Impact on child:
	Impact on family members:

GROOMING							
Does your child have difficulty with grooming activities? Indicate all that apply.	Tooth brushing ☐	Bathing ☐	Hair brushing/ Combing ☐	Face washing ☐	Haircuts ☐	Nail trimming ☐	Blowing nose ☐
	Please comment:						
Does your child avoid grooming devices? Indicate all that apply.	Electric toothbrushes ☐	Barber's clippers ☐	Nail clippers ☐	Dentistry tools ☐	Others: ☐		
	Please comment:						
What routines do you follow that are helpful for getting your child to participate in grooming activities?	Please comment:						

What happens if this routine is disrupted?	Impact on child:					
	Impact on family members:					
DRESSING						
Which clothing is your child able to take off independently? Indicate all that apply.	Shirt ☐	Pants ☐	Underwear ☐	Shoes ☐	Sock ☐	Coat ☐
Which clothing is your child able to put on independently? Indicate all that apply.	Shirt ☐	Pants ☐	Underwear ☐	Shoes ☐	Sock ☐	Coat ☐

Which fasteners can your child manage independently? Indicate all that apply.	Snaps ☐	Zippers ☐	Buttons (unbutton & button) ☐	Ties shoes ☐	
				Was it a struggle learning to tie?	
				NO ☐	YES ☐

Is your child selective in the types of clothing textures he/she will wear?	NO ☐	YES ☐
		What types of clothing textures are preferred?
		What clothing textures are avoided?
Does your child prefer to wear minimal clothes, regardless of weather?	NO ☐	YES. ☐ Please comment.
Does your child prefer clothing to cover entire body or dress in layers, regardless of the weather?	NO ☐	YES. ☐ Please comment.
Does your child frequently adjust clothing, as if uncomfortable?	NO ☐	YES. ☐ Please comment.

Do tags in clothing or seams in socks bother your child?	NO ☐	YES ☐				
		What type of behaviour/reaction is seen?				
What routines do you follow that are helpful for getting your child to participate with dressing?	Specify.					
What happens if this routine is disrupted?	Impact on child:					
	Impact on family members:					
TOILET TRAINING						
Is your child currently toilet trained for bladder?	NO ☐	YES ☐				
		At what age?				
Is your child currently toilet trained for bowel?	NO ☐	YES ☐				
		At what age?				
Does your child experience urinary/bowel issues? Indicate all that apply.	Incontinence during the day ☐	Bedwetting ☐	Constipation ☐	Loose stools ☐	Lack of awareness ☐	
	How often?	How often?	How often?	How often?	How often?	
Does your child wear a nappy or pull-up at night?	NO ☐	YES ☐				
What routines do you follow that are helpful for getting your child to participate in toileting?	Specify:					
What happens if this routine is disrupted?	Impact on child:					
	Impact on family members:					

SOCIAL FUNCTION/FAMILY LIVING		
Are you limited in attending family/social gatherings because of your child's behaviour/ reactivity to events?	NO ☐	YES. ☐ Please comment.
Is your child unable to attend birthday parties?	NO ☐	YES. ☐ Please comment.
Are you unable to leave your child alone with familiar, but not routine, caregivers for child care?	NO ☐	YES. ☐ Please comment.
Is your family unable to maintain relationships with other families?	NO ☐	YES. ☐ Please comment.
Is your family unable to pursue hobbies and interests?	NO ☐	YES. ☐ Please comment.
What routines do you follow that are helpful for getting your child to participate in social situations?	Specify.	
What happens if this routine is disrupted?	Impact on child:	
	Impact on family members:	
COMMUNITY		
Is your child unable to eat out at restaurants?	NO ☐	YES. ☐ Please comment
Is your child uncomfortable on elevators, escalators, or in cars?	NO ☐	YES. ☐ Please comment.

Does your child avoid busy, unpredictable environments?	NO ☐	YES. ☐ Please comment.
Does your child have an excessive reaction to light touch sensation?	NO ☐	YES ☐
		What type of reaction/behaviour is seen?
Is your child unresponsive to being touched or bumped?	NO ☐	YES ☐
Does your child have an excessive reaction if bumped unexpectedly?	NO ☐	YES. ☐ Please comment.
Does your child exhibit a lack of safety awareness?	NO ☐	YES. ☐ Please comment.
Does your child have difficulty travelling on a variety of public transportation?	NO ☐	YES. ☐ Please comment.
Does your child have difficulty flying on planes?	NO ☐	YES. ☐ Please comment.
Is your child unable to attend sleepovers?	NO ☐	YES. ☐ Please comment.
Does your child have difficulty with loud, crowded sporting events?	NO ☐	YES. ☐ Please comment.
Does your child have difficulty sitting through public performances?	NO ☐	YES. ☐ Please comment.

Does your child have difficulty in the grocery store?	NO ☐	YES. ☐ Please comment.
Does your child have difficulty with long car rides?	NO ☐	YES. ☐ Please comment.
Does your child have trouble standing in a queue?	NO ☐	YES. ☐ Please comment.

SOCIAL INTERACTION

Does your child exhibit aggressive behaviour?	NO ☐	YES ☐			
		Is it directed towards him/herself?	NO ☐	YES ☐	
		Is it directed towards others?	NO ☐	YES ☐	
What types of behaviours are exhibited?	Biting ☐	Pinching ☐	Kicking ☐	Hitting ☐	Others:
Does your child exhibit tantrums?	NO ☐	YES ☐			
		How frequently do they occur?			
		What triggers tantrums?			
		On average, how long does a tantrum last?			
		Describe strategies that are effective for helping your child calm during a tantrum.			
		Are tantrums a source of distress to other members of the family?	NO ☐	YES ☐	
Is your child easily frustrated, anxious or overwhelmed?	NO ☐	YES. ☐ Please comment.			
Is your child overly dependent on parent(s) or clingy?	NO ☐	YES ☐			
		Are separations challenging?	NO ☐	YES ☐	
Does your child easily escalate from whimper to intense cry?	NO ☐	YES. ☐ Please comment.			

If your child uses atypical, repetitive behaviours, which behaviours are demonstrated? (Indicate all that apply.)	Hand flapping ☐	Rocking ☐	Head banging ☐	Jumping ☐	Smelling ☐
	Breath holding ☐	Humming ☐	Self-talk ☐	Biting ☐	Mouthing objects ☐
	Visual fixing ☐	Spinning ☐	Teeth grinding ☐	Others:	
Does your child struggle with transitions between activities?	NO ☐	YES ☐			
		How long does it take to transition, on average?			
		What transitions are difficult? YES ☐ NO☐		Please comment.	
		What strategies are used to help transitions?		Please comment.	
		Does difficulty transitioning cause distress to other family members?		NO ☐	YES ☐
				Please comment.	
Does your child struggle when there is excessive auditory input in his/her environment?	NO ☐	YES ☐			
		How does your child react?			
Does your child struggle around individual with certain voice pitches?	NO ☐	YES. ☐ Please comment.			
Does your child struggle to communicate own needs?	NO ☐	YES. ☐ Please comment.			
What is your child's primary form of communication?	Talking ☐	Signing ☐	Sounds/ Vocalisations ☐	Pointing/ Gesturing ☐	Crying/ screaming ☐
How often does your child make eye contact during conversation?	Less than 25% of the time ☐	25% of the time ☐	50% of the time ☐	75% of the time ☐	100% of the time ☐

How often does your child orient to his/her name being called?	Less than 25% of the time ☐	25% of the time ☐	50% of the time ☐	75% of the time ☐	100% of the time ☐
Does your child have difficulty separating from parent or caregiver?	NO ☐	YES. ☐ Please comment.			
Does your child appear to have an awareness of others?	NO ☐	YES. ☐ Please comment.			
Does your child appear to have an awareness of self?	NO ☐	YES. ☐ Please comment.			
Does your child lack fear of strangers?	NO ☐	YES. ☐ Please comment.			
How does your child react in new/unfamiliar situations?	Please comment.				
Does your child have difficulty paying attention in noisy environments?	NO ☐	YES. ☐ Please comment.			
Does your child regularly avoid initiation of social interaction?	NO ☐	YES. ☐ Please comment.			
Does your child avoid maintaining social interaction?	NO ☐	YES. ☐ Please comment.			
Does your child experience difficulties with language expression? (Indicate all that apply.)	NO ☐	YES ☐			
		Easily frustrated, anxious or overwhelmed ☐	Frequently mispronounces words (i.e. bisghetti) ☐	Poor articulation, difficult to understand ☐	Difficulty making choices ☐
		Flat, monotonous voice ☐	Hesitant speech ☐	Tendency to stutter ☐	Difficulty expressing emotions verbally ☐

What routines do you follow that are helpful for getting your child to socialise?	Specify.					
What happens if this routine is disrupted?	Impact on child:					
	Impact on others:					
PLAY SKILLS/PEER INTERACTION						
Is your child destructive toward toys?	NO ☐	YES. ☐ Please comment.				
Does your child struggle to play alone (excluding TV watching)?	NO	YES. ☐ Please comment.				
How long is your child able to play alone?	1-2 minutes ☐	2-5 minutes ☐	5-10 minutes ☐	10-30 minutes ☐	30+ minutes ☐	
What are your child's preferred play activities?	Please specify.					
How much time per day is spent in the following activities?	Passive activities (i.e. TV, computer)	Movement activities (i.e. playground, roughhouse play, sports)	Learning/interactive activities			
Does your child struggle playing with other children? (Indicate all that apply.)	NO ☐	YES ☐				
		Parallel play – playing alongside other children ☐	Interactive play – playing with other children ☐	Structured group play ☐	Making friends ☐	Pretend play ☐
Is your child preoccupied with seeking intense movement during play? (Indicate all that apply.)	NO ☐	YES ☐				
		Spinning ☐	Bouncing ☐	Crashing ☐	Jumping ☐	Rocking ☐	Others:

Does your child have a strong desire for structure or control?	NO ☐	YES. ☐ Please comment.				
Does your child struggle to play in familiar settings?	NO ☐	YES. ☐ Please comment.				
Does your child struggle to play in unfamiliar settings?	NO ☐	YES. ☐ Please comment.				
Which playground equipment will your child play on? (Indicate all that apply.)	Swings ☐	Monkey bars ☐	Crawl tunnels ☐	Vertical climbers ☐	Merry-go-round ☐	Ladders ☐
	Slide ☐	Climbing wall ☐	Bridges ☐	Teeter totter ☐	Spring riders ☐	Others:
Which playground equipment does your child avoid? (Indicate all that apply.)	Swings ☐	Monkey bars ☐	Crawl tunnels ☐	Vertical climbers ☐	Merry-go-round ☐	Ladders ☐
	Slide ☐	Climbing wall ☐	Bridges ☐	Teeter totter ☐	Spring riders ☐	Others:
Does your child avoid certain types of toys (i.e. textured toys)?	NO ☐	YES. ☐ Please comment.				
Does your child exhibit poor safety awareness of engage in activities that are potentially dangerous (i.e. jumping without regard)?	NO ☐	YES. ☐ Please comment.				
Does your child avoid any of the following "messy" activities? (Indicate all that apply.)	Sand ☐	Playing in the grass ☐	Finger paint ☐	Play-doh ☐	Glue ☐	Others:
Which surfaces does your child have difficulty with? (Indicate all that apply.)	Ascending stairs ☐	Descending stairs ☐	Grass ☐	Gravel driveways ☐	Woodchips ☐	Sand ☐	Others:

Does your child have poor depth perception (i.e. ducks or blinks when ball is thrown to him/her, difficulty with stairs)?	NO ☐	YES ☐				
Is your child unable to pull up on the monkey bars with bent arms and legs?	NO ☐	YES☐				
Is your child unable to maintain bent arms and legs while moving bar to bar on the monkey bars?	NO ☐	YES ☐				
Which gross motor skills does your child have difficulty with in comparison to same age peers?	Hopping ☐	Jumping ☐	Skipping ☐	Running ☐	Riding a tricycle or bicycle ☐	
SCHOOL SKILLS						
Where does your child attend pre-school or school?	Home school	Daycare	Special needs pre-school class	Regular education class	Special education class	Other:
Does your child exhibit a hand preference?	NO ☐	YES ☐				
		Right ☐	Left ☐			
		Established at what age?				
Does your child frequently change his/her grasp on pencils/other tools?	NO ☐	YES. ☐ Please comment.				
Which writing skills does your child struggle with/avoid? (Indicate all that	Drawing/ Colouring ☐	Tracing ☐	Copying ☐	Handwriting ☐		

apply.)	Use of graded pressure ☐ Too much ☐ / Too little ☐		Stabilisation of paper while drawing/writing ☐	Proper desk posture ☐	Others:
Which fine motor skills does your child struggle with/avoid? (Indicate all that apply.)	Grasping and manoeuvring scissors ☐			Performing 2 different tasks at the same time (i.e. hold and turn paper while cutting, cut food using knife and fork) ☐	
Which skills does your child struggle with? (Indicate all that apply.)	Finding items within a hidden picture ☐		Phonetic learning ☐	Telling time ☐	Sequencing months of the year ☐
	Puzzles and construction/ manipulation of materials ☐		Spelling ☐	Responding promptly to verbal instruction ☐	Writing numbers & letters correctly (without frequent reversals) ☐
Is your child's draw-a-person immature for age?	NO ☐	YES. ☐ Please comment.			
Does your child write up/down hill on paper?	NO ☐	YES. ☐ Please comment.			
Which of the following visual-related skills does your child struggle with? (Indicate all that apply.)	Poor eye teaming ☐	Using peripheral more than central vision ☐	Keeping eyes too close to work ☐	Closing/ covering one eye while doing near work ☐	Eye strain after reading a short period of time ☐
	Copying from board to paper ☐	Short attention span in reading/ Copying ☐	Turning head when reading across a page ☐	Losing place often during reading ☐	Needing finger or marker to keep place while reading ☐
	Reading comprehension ☐	Reverses letters or words ☐	Rereads or skips words when reading ☐	Doesn't look when manipulating objects ☐	Tracking a moving object with head movement ☐
Does your child have difficulty sitting still?	NO ☐	YES ☐			
		Does your child fidget while listening?		NO ☐	YES ☐

MOVEMENT SKILLS			
Does your child become overly excited after movement activity?	NO ☐	YES. ☐ Please comment.	
Does your child display the following movement difficulties? (Indicate all that apply.)	Avoids activities where feet leave the ground ☐	Avoids/fear activities requiring balance ☐	Avoids age-appropriate gross motor activities ☐
	Loses balance/trips easily or frequently ☐	Dislikes being moved ☐	Drags hand or bangs object along wall when walking ☐
	Stamps/slaps feet on ground when walking ☐	Drags feet or has poor heel-toe pattern when walking ☐	Unable to walk on alternating treads on stairs ☐
	Excessive dizziness from swinging, spinning, or riding in a car ☐	Resists having head tiled backwards ☐	Fears falling when no real danger exists ☐
	Fearful of being tossed in the air or turned upside down ☐	Holds head upright when leaning or bending over ☐	Dislikes inversion (going upside down) ☐
	Confuses left and right ☐	Lethargic and inactive ☐	Difficulty moving between rooms ☐
	Difficulty moving from one floor surface to another ☐	Poor body scheme awareness ☐	Leans on objects/people for stability ☐
	Poor sense of direction or awareness of space in relationship to self ☐	Limited rotation of hip and/or shoulder girdle around central core of body ☐	Moves with quick bursts of activity rather than with sustained effort ☐
	Sets jaw or locks major joints for stability when applying effort ☐	Seems weaker or tires more easily than peers ☐	Poor coordination or sense of rhythm ☐
Does your child like to be wrapped tightly in a sheet or blanket or seek tight spaces?	NO ☐	YES. ☐ Please comment.	

Does your child shake head vigorously or assume an upside down position frequently?	NO ☐	YES. ☐ Please comment.			
Is your child able to conceive and organise a plan of action to direct play/movement?	NO ☐	YES. ☐ Please comment.			
DAILY ENVIRONMENT/INTERACTION					
Does your child demonstrate an irrational fear of any of the noisy appliances or machines? (Indicate all that apply.)	Vacuum cleaner ☐	Hair dryer ☐	Fans ☐	Blender ☐	Coffee grinder ☐
	Toilet flushing ☐	Air vents ☐	Lawn mower ☐	Leaf blower ☐	Others:
	Please comment.				
Does your child demonstrate an irrational fear of any of the following noisy sounds? (Indicate all that apply.)	Jets/airplanes ☐	Trucks ☐	Thunder ☐	Others:	
	Please comment.				
Is your child confused about the direction of sounds?	NO ☐	YES. ☐ Please comment.			
Does your child hear sounds that others do not or before others notice?	NO ☐	YES. ☐ Please comment.			
Does your child cover ears to shut out objectionable auditory input or over-react to unexpected sounds?	NO ☐	YES. ☐ Please comment.			

Does your child attend to auditory input less than a few seconds?	NO ☐	YES. ☐ Please comment.
Does your child appear under- or oversensitive to pain?	NO ☐	YES. ☐ Please comment.
Does your child dislike having eyes covered or being in the dark?	NO ☐	YES. ☐ Please comment.
Is your child overly sensitive to lights/sunlight?	NO ☐	YES. ☐ Please comment.
Does your child seem to need to "fix" the environment (i.e. arrange objects, chairs, shut doors)?	NO ☐	YES. ☐ Please comment.
Does your child avoid environments/ objects with certain odours?	NO ☐	YES. ☐ Please comment.
Does your child seek environments/ objects with certain odours?	NO ☐	YES. ☐ Please comment.
SUMMARY		
What do you perceive as your child's strengths?	Please comment.	
What are the primary concerns prompting this assessment/ intervention?	Please comment.	
What are your hopes and goals from assessment and/or intervention?	Please comment.	

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