TRAFFORD COUNCIL

Pennine Care NHS
NHS Foundation Trust

Trafford Children's Therapy Service
2nd Floor, Waterside House
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M33 7ZF

Tel: 0161 912 4495/4335

Motor Skills Questionnaire for PARENTS of Pre-school Children

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 …… Tel No ……

Mob No ……...

Work No ……..

School ……

GP Name and Address ……

…… Tel No ……..

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Parents full name ……..

Relationship to child ……

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

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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 ……

5. Is your child developing any independence skills with dressing?

6. 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	

7 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

8 What are your child's interests:-

9 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 particular activities?

10b Do you feel that your child has improved skills with practise?

11 What do you feel your child's main strengths are?

12 What are your child's main difficulties, which cause you most concern?

13 Any other comments?