OCCUPATIONAL THERAPY TEACHER QUESTIONNAIRE

Dear Teacher

A child in your class has been referred for an occupational therapy assessment. I would be grateful if you could please answer the following questions to enable me to have a clear understanding of the child's present difficulties. Please can you return the completed form to the child's parents or email it directly to me. Thank you.

A. GENERAL

Date: _____

Child's Name: _____

Age: _____

Class: _____

Teacher's Name and Surname: _____

School: _____

Address: _____

Telephone Number: _____

Email Address: _____

B. SCHOOL PERFORMANCE

Please supply more details where necessary.

1. Is the child happy at school? Please elaborate: _____

_____

2. Is the child able to separate from his/her parents appropriately? _____

_____

3. Is the child frequently irritable or clingy? _____

_____

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4. Where does the child sit in the classroom? Is this by choice or by direction? _____

_____

5. Does the child have difficulty carrying out instructions? _____

_____

6. Does the child tend to fidget excessively in class?_____

_____

7. Is the child easily distracted by sights and sounds etc? _____

_____

8. Is the child overly active and hard to calm down?_____

_____

9. Does the child form good relationships with his/her peer group? _____

_____

10. Does the child frequently bump and push other children and tend to play too rough with others? _____

_____

11. Does the child complain when other children 'bump' into him/her? _____

_____

12. Does the child over or under react to physically painful experiences? If so, which one. Please elaborate: _____

_____

13. Does the child tend to withdraw from a group or seem irritable in close quarters? _____

_____

14. Does the child have any extra support in the classroom? _____

_____

15. Does the child have difficulty organising him/herself ? _____

_____

16. Is the child's work (drawing, colouring etc) age appropriate? _____

_____

17. What part of the school day does the child like/dislike? _____

_____

18. Does the child have difficulty/enjoy/avoid gross motor play (eg climbing frames, swings, soccer etc)? _____

_____

19. Does the child appear to have difficulty with balance or fall/bump into things frequently?

_____

_____

20. Does the child appear to fear falling or heights? _____

_____

21. What type of play does the child choose to engage in most frequently? _____

_____

22. Does the child avoid new activities or prefer playing games that he/she is confident in?

_____

_____

23. Are there any activities that the child avoids in class? _____

_____

24. Does the child sit with a slouch or partly on and off the chair or does the child prefer to stand to work?_____

_____

25. Have you or has any other teacher implemented strategies to assist the child? If so, are these helpful? _____

_____

26. Does the school have any other concerns not covered above? Please elaborate _____

_____

_____

_____

_____

SIGNATURE OF TEACHER:_____ **DATE:**_____