



Parent Questionnaire

Please complete the following questionnaire giving as much information as you can.
Tick or circle all responses where appropriate.

Family Details

Child's Name:	Date of Birth:
Parent's/Guardian's Name:	Child's Age:
Home Address	Home Tel Number:
Post Code:	Mobile Number:
	E-mail:
Brothers/Sisters and ages ➤ ➤ ➤ ➤	List of people living at home: ➤ ➤ ➤ ➤
Is your child adopted? Yes/No	Is your child aware of this? Yes/No
General Practitioner Name:	
Address:	
Post Code	Telephone:

Concerns and Expectations

Briefly list the main concerns about your child:

What would you like to gain from your sessions e.g. support, practical help, reports?

Pregnancy birth history

Did you experience.....

An uneventful (normal pregnancy)? Excessive sickness during pregnancy?
 Difficulties during pregnancy? Did this continue throughout pregnancy?
 If so what? Describe if appropriate

Was your labour....?

Normal Forceps, Ventouse
 Caesarean section Premature By how much?
 Late By how much?

Any post-natal problems?

Post natal depression
 Were there any difficulties in the
 First month after birth? If so, what?

Developmental History (please refer to your 'parent-held record book' (Baby Book))

At what age did your child: Sit unsupported:
 Crawl:
 If not, did she 'bottom shuffle' or 'commando crawl'
 Walk: Talk:

At what age was your child toilet trained? By day:
 By night
 Any current problems?

Did your child have any feeding difficulties? Yes/No
 If so, please describe:

Did your child have any feeding difficulties? Yes/No
 If so, please describe.

Was your child: Breast fed? Bottle fed?

Medical History

Has anyone in your family suffered from....? If so, who, and what was wrong?

Eczema Hayfever
Asthma Epilepsy

Speech and language delay/difficulties
Developmental problems, e.g. dyslexia
Squints/turns
Does anyone in the family wear glasses?

If so, why?

Does your child have/has your child had?

If so, please describe and give dates

A series illness
A series injury
Surgery
Allergies
Convulsions/fits
History of Glue ear
Problems with sleeping
Head injuries
Headaches or migraines
Mental health problems
Difficulties with digestion
Candida
Any other

Current medication:

Current treatment programs:

Hearing Test Date Outcome:

Sight Test Date Outcome:

Does your child wear glasses? Yes/No

If yes, why?

Has your child had an assessment by any of the following?

Occupational therapist date	<input type="checkbox"/>	Behavioural Optometrist Date	<input type="checkbox"/>
Physio therapist date	<input type="checkbox"/>	Paediatrician Date	<input type="checkbox"/>
Psychiatrist Date	<input type="checkbox"/>	Speech and Language Therapist Date	<input type="checkbox"/>
Clinical Psychiatrist\ Date	<input type="checkbox"/>	Other	
Psychologist Date	<input type="checkbox"/>		
Educational Psychologist date	<input type="checkbox"/>		
Dietician date	<input type="checkbox"/>		

Educational History

Name of School:	
Address of School	
Post Code	Telephone number: E-mail address:
Teachers name:	
Is your child on a stage of 'The Code of Practice'?	Yes/No
Has your child been Statemented as having a Special Educational Need? If yes, what stage and why?	Yes/No
Describe any extra support your child receives at school	
Has your child been away from school for any length of time? Please give details	
Are you aware of any problems at school? If so, please describe	

Social and Emotional Development

Which would you say best describes your child? *(tick as many as appropriate)*

Quiet <input type="checkbox"/>	Withdrawn <input type="checkbox"/>
Overactive <input type="checkbox"/>	Anxious <input type="checkbox"/>
Upset by failure <input type="checkbox"/>	Shy <input type="checkbox"/>
Impulsive/no fear of danger <input type="checkbox"/>	Behavioural problems at home <input type="checkbox"/>
Craving attention <input type="checkbox"/>	Behavioural problems at school <input type="checkbox"/>

Does your child.....? *(tick as appropriate)*

<p>Have a good relationship with his/her siblings? <input type="checkbox"/></p> <p>Make friends easily: <input type="checkbox"/></p> <p>Understand the rules of games? <input type="checkbox"/></p> <p>Understand jokes? <input type="checkbox"/></p> <p>Play with children: Older <input type="checkbox"/> Younger <input type="checkbox"/> Same age <input type="checkbox"/></p>	<p>Have any unusual fears? If yes, please describe.</p> <p>Have favourite: Toys <input type="checkbox"/> Family Outings <input type="checkbox"/> Interests <input type="checkbox"/></p> <p>If so What</p> <p>Belong to any after school groups If so, what? <input type="checkbox"/></p>
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Listening and Communication Skills

Does your child.....?

Seem oversensitive to sound? <input type="checkbox"/>	Likes to sing? <input type="checkbox"/>
Misinterpret simple questions/instructions? <input type="checkbox"/>	Dislike singing? <input type="checkbox"/>
Get confused by similar sounding words? <input type="checkbox"/>	Have difficulty with speech sounds? <input type="checkbox"/>
Use gesturing only to make themselves understood? <input type="checkbox"/>	Appear to listen but not understand? <input type="checkbox"/>
Use gestures to refine verbalisation? <input type="checkbox"/>	Have a hesitant speech? <input type="checkbox"/>
	Understand other's gestures and Expressions? <input type="checkbox"/>

Sensory Motor Behaviour

Does your child.....

- | | | | |
|--|--------------------------|--|--------------------------|
| Get car sickness easily? | <input type="checkbox"/> | Craves hugs and cuddles? | <input type="checkbox"/> |
| Get agitated by the close proximity to other people? | <input type="checkbox"/> | Take fingers/toys to mouth? | <input type="checkbox"/> |
| Get dizzy easily? | <input type="checkbox"/> | Dislike certain food textures? | <input type="checkbox"/> |
| Have extreme dislike of nail cutting? | <input type="checkbox"/> | Have an aversion to excessive noise? | <input type="checkbox"/> |
| Appear fearful of balance or climbing? | <input type="checkbox"/> | Have an excessive need to touch things? | <input type="checkbox"/> |
| Crave spinning or swinging? | <input type="checkbox"/> | Be irritated by certain textures? | <input type="checkbox"/> |
| Reluctantly participate in sports? | <input type="checkbox"/> | Have an extreme dislike of anything?
Please describe: | <input type="checkbox"/> |

Co-ordination and self help skills

Does your child have difficulties with	
Organising him/herself? <input type="checkbox"/>	Standing on one leg? <input type="checkbox"/>
Dressing – sequencing, orientation of garments? <input type="checkbox"/>	Hopping? <input type="checkbox"/>
Undressing? <input type="checkbox"/>	Jumping? <input type="checkbox"/>
Putting on socks? <input type="checkbox"/>	Skipping? <input type="checkbox"/>
Putting shoes on correct feet? <input type="checkbox"/>	Riding a bike? <input type="checkbox"/>
Tying shoe laces? <input type="checkbox"/>	Using playground equipment? <input type="checkbox"/>
Fastening buttons? <input type="checkbox"/>	Walking on walls? <input type="checkbox"/>
Managing cutlery? <input type="checkbox"/>	Walking up/down stairs? <input type="checkbox"/>
Managing personal toilet appropriately (wiping bottom etc.)? <input type="checkbox"/>	Pencil tasks – writing drawing? <input type="checkbox"/>
managing personal hygiene (washing etc.)? <input type="checkbox"/>	Using scissors? <input type="checkbox"/>
Brushing teeth? <input type="checkbox"/>	Dislike playing with toys that require manipulation, e.g. Lego? <input type="checkbox"/>

Visual skills

Does your child....?	
Seem to scan but not understand what they have read? <input type="checkbox"/>	Fail to recognise known words? <input type="checkbox"/>
Dislike playing with puzzles? <input type="checkbox"/>	Read better from flash cards than a book? <input type="checkbox"/>
Need to use a finger to follow print? <input type="checkbox"/>	Have poor letter formation? <input type="checkbox"/>
Have difficulty colouring in? <input type="checkbox"/>	Have inadequate spacing? <input type="checkbox"/>
Follow with head movements when reading? <input type="checkbox"/>	Have excessive spacing? <input type="checkbox"/>
Have difficulty copying form the board? <input type="checkbox"/>	Seem to write off the line? <input type="checkbox"/>
Lose their place on the page frequently? <input type="checkbox"/>	Turn or tilt their head? <input type="checkbox"/>
Blink/squint? <input type="checkbox"/>	Close/cover one eye? <input type="checkbox"/>
Have one eye truing in/out? <input type="checkbox"/>	

Any other information

Please use this space to include anything that you feel should be included.

Please make sure you have read and understood and signed the Terms and Conditions form and the Consent of Use form. No session can begin without this being made present prior to or at the initial session.

Signed..... Name..... Date.....

You may return the questionnaire to me by post or bring it along with you.

Thank you for your time
Simon Olding, MovementInMind, 63 Bedford Road, Cranfiled, Bedfordshire, MK43 0EX

Please read this Consent of Use carefully

A signed, returned consent form will mean that you have agreed to have the named child or individual for whom you are the legal guardian participate in the treatment sessions run by Simon Olding and MovementInMind, and that you have read and agreed to the contents of this form.

I understand that the systems and therapies are for educational, developmental and personal growth purposes only and has not been reviewed by the FDA or any other organisation, and Advanced Brain Technologies, LLC (ABT), Educational Kinesiology Foundation (International Foundation), the Institute of Touch for Health, the HeartMath® Institute or the developers of the QXCI Scio make no medical claims concerning its use.

I understand that there will be physical contact made during a session. I understand that this is integral to the treatment session. I give permission for appropriate physical contact during a session but have the right to stop a session if I feel it to be inappropriate.

I further understand that there may be no benefit in any way from The Listening Program, the Edu-K systems, Touch for Health, HeartMath®, Scio or any programs I offer. I understand that if there should be any experience of physical and/or behaviour discomfort during or possibly resulting from use of any program, I will not hold ABT, Touch for Health, Edu-K Foundation, The Institute of HeartMath or the Quantum Group for Scio bio-feedback therapy, nor its agent, authorized providers, dealers, employees, or associates responsible for the physical and/or behavioural problems.

I understand that all systems and programs are only to be used with the individual named on this form.

I give my consent for _____ (Name of Participant)
to participate in use of The Listening Program or a MovementInMind treatment session.

I have read, understand, and agree with the information outlined in this consent form.
Signature of Parent or Legal Guardian

Parent/Guardian: _____ (Relationship) _____

Date: _____

*Please keep a copy of the Consent of Use form for your records and send or bring the original to MovementInMind

Terms and Conditions

You agree to comply with the terms highlighted in the Consent of Use form and have signed it accordingly.

Cancellations

You have the right to cancel any appointment. Cancellations must be confirmed at least 2 days before the appointment.

Appointments cancelled within 12 hours will have a £20 charge.

Missed appointments will have a £30 charge.

I reserve the right to cancel appointments but will reschedule them at a mutually convenient time.

I reserve the right to discontinue treatment at my discretion.

Purchases and Session

You agree that any session or order made will be honoured to the full amount agreed at the time of either the session or the ordering.

I have read the Terms and Conditions and agree to the comply with them.

Name in print

Date

Signature