face | Families of Alberta for Conductive Education

## Assessment Questionnaire

A completed questionnaire is required for each child who is to attend a Conductive Education Program. Complete the questionnaire as fully as possible.
This information will be kept confidential.

| | |
|---|---|
| Child's First name: Initial(s): Last name: | |
| Name Commonly Used: | Date of Birth (mm/dd/yy): |
| Address: | |
| City: | |
| Province: | PC: |
| Male or Female: | |
| Mother's/Guardian's Name: | Father's/Guardian's Name: |
| Home #: | Home #: |
| Work #: | Work #: |
| Cell #: | Cell #: |
| E-mail: | E-mail: |
| Address: Same as child or | Address: Same as child or |
| City: | City: |
| Province: PC: | Province: PC: |
| Child lives with: ☐ Parents ☐ Mother ☐ Father ☐ Guardian(s) | |

Emergency Contacts:

| | |
|---|---|
| #1 Contact: | Relationship: |
| Cell #: | Home #: |
| | |
| #2 Contact: | Relationship: |
| Cell #: | Home #: |

1. Child's Diagnosis: _____
Date of Diagnosis (mm/dd/yy):_____

Complete description of your child's diagnosis (include secondary implications of the primary diagnosis). Use a separate sheet if necessary.

_____

2. Please give details of prenatal/labour conditions (weeks of gestation, Caesarean section, hospitalization etc.)

3. How many siblings does the child have and what are their ages?

4. Does your child attend school? _____ grade_____

Is it a school for children with special needs or integrated setting?_____

How many children are in the classroom?_____

Does the child have an educational assistant in the classroom?_____

5. Motor Development (check the most appropriate answer):

Can your child do the following? Comments

Lift head ☐ Yes ☐ No _____

Crawl ☐ Yes ☐ No _____

Sit unsupported ☐ Yes ☐ No _____
If support is required please explain: _____

Stand without support ☐ Yes ☐ No _____
If support is required please explain: _____

Walk without support ☐ Yes ☐ No _____
If yes, how far? _____
If support is required, please explain? _____

Speak ☐ Yes ☐ No _____
If non-verbal, how does your child communicate? _____

Is your child toilet-trained? ☐ Yes ☐ No _____

Does your child have a hearing impairment ☐ Yes ☐ No
If yes, please describe: _____

Does your child have a visual impairment ☐ Yes ☐ No
If yes, please describe: _____

Does your child difficulty with swallowing and/or chewing: ☐ Yes ☐ No

6. Please describe any treatment or therapies that your child is currently receiving.

7. Please describe any treatment or therapies that your child has received in the past and not currently receiving.

8. If your child has received Conductive Education in the past please give details of where, how long, intensity and improvements.

9. Please detail all the equipment and aids that your child uses (AFOs, special shoes, leg/arm gaiters, walkers, wheelchairs etc.)

10. Please check Yes or No and give the approximate date(s):

| Condition | | Date (mm/dd/yy) (approx) | Condition | | Date (mm/dd/yy) (approx) |
|---|---|---|---|---|---|
| Chicken Pox | ☐ Yes ☐ No | _____ | Heart Condition | ☐ Yes ☐ No | _ |
| Fainting | ☐ Yes ☐ No | _____ | Adenoidectomy | ☐ Yes ☐ No | _ |
| Asthma | ☐ Yes ☐ No | _____ | Hernia Repair | ☐ Yes ☐ No | _____ |
| Tuberculosis | ☐ Yes ☐ No | _____ | Kidney Trouble | ☐ Yes ☐ No | _ |
| Tonsillectomy | ☐ Yes ☐ No | _____ | Measles, German | ☐ Yes ☐ No | _ |
| Hepatitis | ☐ Yes ☐ No | _____ | Whooping Cough | ☐ Yes ☐ No | _ |
| Mumps | ☐ Yes ☐ No | _____ | Hay Fever | ☐ Yes ☐ No | _____ |
| Measles, Red | ☐ Yes ☐ No | _____ | Diabetes | ☐ Yes ☐ No | _____ |
| Severe Stomach | ☐ Yes ☐ No | _____ | Scarlet Fever | ☐ Yes ☐ No | _____ |
| Frequent Colds | ☐ Yes ☐ No | _____ | Sinus Trouble | ☐ Yes ☐ No | _ |

11. Operations: State any operations that your child has had and indicate which were related to their primary diagnosis:

_____

_____

12. Has your child had any major illnesses recently?

_____

13. Give the last approximate dates of immunizations:

| Immunization | Date (mm/dd/yy) | Immunization | Date (mm/dd/yy) |
|---|---|---|---|
| Tetanus | _____ | Diphtheria | _____ |
| Polio | _____ | HIB | _____ |
| Pertussis | _____ | Other | _____ |

14. Does your child have any allergies?

_____

_____

Carries Ana kit: ☐ Yes ☐ No _____

Carries Epipen: ☐ Yes ☐ No _____

15. Medical Conditions: Please describe any medical conditions (e.g., heart problem, seizures, etc.) that your child has:

_____

_____

16. Does your child exhibit any emotional or behavioural difficulties? Do they have any unusual fears? How do you deal with your child if he/she has difficult behaviour?

_____

_____

17. How would you suggest that the Conductor deal with your child if their behaviour becomes disruptive to the program?

_____

18. What are the child's favourite toys or activities?

_____

19. Please list a minimum of three goals for this program session.

_____
_____
_____
_____
_____

## Declaration and Signature

I hereby state that the above information is true to the best of my knowledge

_____ _____

Parent / Guardian Signature Date