SENSORY SPACE
THERAPY CENTRE

PARENT QUESTIONNAIRE

Fill form in capital letters

Child's name, surname:	
Child's DOB:	
Address:	
Parent(s)/guardian(s)names(s) and phone number(s), email:	
Does your child suffer from any of the following?: Epilepsy: Ear infections: Chest infections:	
Any other illness we should be aware of? If YES, please specify:	
Does your child take any regular medications: If YES, please specify:	YES NO
Existing diagnosis (if any):	
Is your child toilet-trained?	YES NO
Is your child verbal? If NO, how does he/she communicate?	
Has your child ever attended any therapy before (SLT, Play Therapy, Art Therapy, Music Therapy etc.)? If YES, please specify:	

Does your child attend mainstream school?: If NO, please provide details: (e.g. ASD class, home tuition etc.):	YES NO
What does your child like/ enjoy?	
What does your child dislike?	
Is there something that easily upsets your child? If YES, please specify:	
What helps to calm your child if he/she gets upset or frustrated?	
Do you have any concerns about your child's social skills and peer interactions? If YES, please specify:	
If there is anything else you may think is important to know please specify:	

Name, surname:_____ Signature: _____

Date: _____