Advance Institute for
The Scotson Technique
Registered Charity: 1026049

Parents' Information prior to the First Evaluation

DATE:…………………

PART 1   Please complete clearly

Full Name(s) of both Parents:………………………………………………………………………………

Address:……………………………………………………………………………………………………..

………

Telephone no. work: …………………………… Telephone no. home: ………….…………………………

Mob/Tel no. mother: ……………………………..…Mob/Tel no. father: ……………..…...………….……

E-mail address: ……………………………………………………………………………….…………..

Occupation: Mother ……………………………….……..Father …..……………………………………...

Name of Child: ……….………………………………………………………………………………..

Age: ……………………..……. Date of Birth: …………..……………..... Gender:...

Diagnosis: ……………………………………………………………………………………….………..

Was your child premature?...........................Was your child ever on a ventilator?..

When you first aware of a problem?...

Did any events early in your child's life appear to make the situation worse?   Yes   No

If yes what?...

Did the mother have any illness or stress during pregnancy?..

Abnormal Symptoms: (Please circle)

Postural   Motor   Cognitive   Behavioural   Seizures   Digestive

What therapies have you used so far? ………………………………………………………………………

What is the first change you would like to see in your child? ……………………….……………………..

How did you find us? (Please circle)

Word of mouth TV/radio Newspaper Magazine From family of child Internet Medical

- **Can you commit yourself to a 6 day weekly programme involving approx 6 five minute period of therapy?** ……………………..……………………………………..
- **Can you commit approximately 3 years to your child's rehabilitation?...**
- **Does your child attend school? ………………………………………………………………………..**

PART 2

Parents' observations **please tick column – if not appropriate, leave blank:**

Functional ability:
Can your child?

	Not at all	Poorly	Moderately	Fairly Well	Well
1. Hold up head					
2. Move limbs usefully					
3. Move of hands usefully					
4. Sit unsupported					
5. Crawl					
6. Walk					
7. Run					
8. Vocalise					
9. Speak					
10. Yawn					
11. Laugh					
12. Sing					
13. See					

Physiological ability:
Can your child?

14. Sleep					
15. Digestion					
16. Bowel movements					
17. Bladder Control					
18. Chew					
19. Swallow	(Stomach fed)				
20. Bowel control					

If Stomach fed, what food does your child take?...

Cognitive:

Can your child?	Not at all	Poorly	Moderately	Fairly Well	Well
1. Respond to surroundings					
2. Recognise people					
3. Communicate					
4. Understand speech					
5. Carry out simple request					
6. Play with others					
7. Play independently					
8. Behave socially acceptable					
9. Concentrate on tasks					
10. Listen to stories					
11. Read					
12. Write					
13. Show normal emotions					
14. Carry out complex requests					
15. Work independently					
16. Work in a group					
17. Give eye contact					
18. Keep still when needed					
19. Concentrate on conversational subject					

Physiological	Yes	No	Frequently
Seizures			
Chest infections			
Colds			
Allergies			
Asthma			
Eczema			

- **If your child has seizures, what time of day or night do they most often occur?**

  ……………………………………………………………………………………………………

- **Please give a brief description of your child's difficulties overall.**

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- **If your child is using any special equipment or supports, please state which:**

  ……………………………………………………………………………………………………

- **Does your child take medication for the epilepsy:…………………..……………………………...……………**
- **If your child is on any medication, please state which: ……………………………………………………….**
- **Have you tried other therapies? Yes No**

  If yes please state which……………………………………………………………………………………
- **Is your child still undertaking other therapies? Yes No**

  If yes please state which..
- **Is your child easily startled by sounds?.......…………………………………………………….…………...**
- **Before coming to Advance, what was the most helpful thing you were told about your child's condition by a member of your child's therapy team:**

……………………………………………………………………………………………………….……

………..

- **Does your child have a typical eating habits?...**
- **Please give an example of your child's daily menu and what time he or she eats?**

Breakfast	Time	Lunch	Time	Supper	Time	Snacks	Time

- **What time in the evening is the last food or drink usually taken?**

  Food:……………………………………… Drink:……………………………………………

Thank you very much for filling in this form.

ATTENTION

Assessment photographs

We do need to look at the trunk structure but it is also lovely to see the children looking smart. Please could you bring smart shorts or bathing costume for boys and girls (bottom part of bikini for girls). If the girls are over 11 please bring crop top and shorts or bikini for them.

Patron: The Countess Sondes
Vice Presidents: Jilly Goolden, Carol Hehir MBE, Ross Minter, Angel Sinclair
Trustees: John Gardiner, Sarah Pratten, Louise Bray, Tracey Hall-Roberts
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