

ADULT QUESTIONNAIRE

Please complete the following questionnaire giving as much information as you can. Tick or circle all responses where appropriate. Please attach extra sheets if necessary.

This questionnaire can also be filled in over the phone. If you would like to do this please contact The Discovery Centre on 01633 432 330.

FAMILY DETAILS

Name: Home Address: Post Code:	Date of Birth: Age: Tel. Number: Fax No: E-mail:
List of people living at home:	
What is the main language you speak at home?	
Description of current employment / study (if applicable): How long have you been in your current job / studying?	

KEY CONCERNS

Briefly list your main concerns:
1.
2.
3.
4.
How do you hope that coming to The Discovery Centre will help you?

Developmental History

Please describe any difficulties you may have had at school:

Did you have any other difficulties when growing up?

Were you bullied? Yes No

Did you miss much time from school? Yes No

Which hand do you write with? Left / Right

Please list your educational history and attainment

Dates	School/College/University	Achievements

Please list your work history (please continue on a separate sheet if needed)

Dates	Employer	Job title	Full time / Part time / Voluntary

Assessment History

Have you ever had an assessment with a health or educational professional (e.g. Occupational Therapist, Speech and Language Therapist, Physiotherapist, Educational Psychologist, Psychiatrist, Dietician etc.)?

If yes, please state who, when and the outcomes of the assessment:

Professional	Date	Outcome

Please attach any reports if available.

Have you been seen previously at The Discovery Centre? Yes No If yes, when?

Medical History

	Do you have or have you had...? If yes, please give details.	Have any family members (i.e. siblings, parents, grandparents, aunts, uncles etc.) had....? If yes, please state who.
Eczema	Yes / No	
Asthma	Yes / No	
Hayfever	Yes / No	
Epilepsy / convulsions / fits	Yes / No	
Joint Hypermobility Syndrome (EDS III)	Yes / No	
Speech and language difficulties	Yes / No	
Developmental difficulties such as dyslexia, dyspraxia, DCD, ADHD, Asperger's Syndrome, Autism Spectrum Disorders etc.	Yes / No	
Mental health problems	Yes / No	
Headaches / Migraines	Yes / No	

Checklist:

This is a checklist to discover a little more about you. We would like you to make a judgement about each activity. Read each sentence and mark how you feel your ability compares to those around you by placing an 'X' in the most suitable box. **Please try to be as honest as possible; there are no right or wrong answers and confidentiality is assured.** Please do not leave any blank answers.

From the checklist, please tick any items you would specifically like to get help with.

		My Ability					Help wanted
		Very poor	Poor	Average	Good	Very good	
	<i>Example: I am good at this compared to others</i>				X		
	<i>Example: I am very poor at this compared to others</i>	X					X
Work/college skills	Tidiness of writing (others are able to read it)						
	Using computers						
	Keeping my attention on one task						
	Remembering to do tasks and assignments						
	Finishing the same amount of work compared to others in a similar position						
	Reading and understanding work given to me						
	Spelling						
Social and Communication	Starting a new conversation						
	Group situations, discussions, meetings						
	Making new friends						
	Interpreting the intentions of others correctly e.g. getting the joke, understanding sarcasm						
	Coping with changes to routine						
	Self-esteem – feeling positive about myself						
Co-ordination	Driving a car						
	Co-ordination – e.g. sports, eating, doing DIY tasks						
	Riding a bike (as a child or now as an adult)						
Organisation & Time Management	Keeping objects and possessions safe and knowing where they are						
	Organisational skills – keeping my desk/equipment in good order, files or notes well kept/tidy						
	Punctuality – being on time or a little early						

		My Ability					Help wanted
		Very poor	Poor	Average	Good	Very good	
Everyday Living Skills	Managing money, paying bills, finance						
	Shopping – handling money and change						
	Finding my way around new places						
	Doing hair, shaving, cleaning teeth, applying make-up (if applicable!)						
	Cooking meals and snacks						

Further information (please add additional sheets if necessary)

What do you consider are your strengths?

How do you like spending your free time?

Do you receive any help? Yes No
 e.g. extra time for exams (how long?), help with some aspects of duties, home care etc.
 Details:

Do you get any disability support/allowances? Yes No
 Details:

BEFORE RETURNING YOUR INFORMATION TO US, PLEASE ENSURE YOU HAVE READ AND UNDERSTOOD THE TERMS AND CONDITIONS STATED IN THE INFORMATION PACK

AS WE ARE UNABLE TO PROCEED UNTIL ALL THE INFORMATION REQUESTED HAS BEEN RECEIVED, PLEASE CHECK YOU HAVE ENCLOSED THE FOLLOWING WITH THIS QUESTIONNAIRE:

- The referral fee A GP consent form
- A photograph of yourself for our records All relevant background information e.g. previous reports from professionals

COULD YOU PLEASE ENSURE WHEN RETURNING ALL THE APPROPRIATE FORMS TO THE CENTRE THAT YOU HAVE THE ENVELOPE WEIGHED AND THE CORRECT AMOUNT OF POSTAGE APPLIED SO AS TO AVOID ANY DELAY IN THE POST. THANK YOU.

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

THANK YOU FOR YOUR CO-OPERATION

Please return to: The Dyscovery Centre, University of Wales, Newport, Allt-Yr-Yn Campus, Newport NP20 5DA