Occupational Therapy Experience Questionnaire

This questionnaire will be used to assist you and your potential employer to determine which Occupational Therapy settings would be best suited to your skills and experience. It will also help us identify areas for future training and development. For the purpose of this checklist Community work involves seeing patients in their own homes across Cambridgeshire and Peterborough.

Contact Details

Name:

Country:

Email Address:

Number of years' experience of working with people with Physical Health and Mental Health problems:

Q1

TREATMENT SETTINGS EXPERIENCE IN Occupational Therapy

Please indicate whether you have ever worked in the Occupational Therapy settings below by inserting **Y** or **N** in the appropriate column. If yes, please state approximately how many years' experience you have had. Please use the comments column to tell us any additional information

Treatment Setting	Yes/ No	If Yes, Approximate Numbers of Years	Comments
Inpatient rehabilitation setting			
Community Occupational Therapy for adults in their own homes			
Community neurological rehabilitation			
Community Intermediate Care			
Admission avoidance and rapid response			

Older people's mental health wards			
Older People Mental health Occupational therapy in community			

Q2

PHYSICAL AND MENTAL HEALTH ILLNESS EXPERIENCE

Please indicate whether you have experience in caring for people with the physical and mental health problems below by replying **Y** or **N** in the appropriate column. If yes, please state approximately how many years' experience you have had. Please use the comments column to tell us any additional information

Physical and Mental Health Illness	Yes/ No	If yes, approximate numbers of years	Comments
Complex frail elderly patients with Long term conditions			
Neurological conditions (MS, MND, Brain injury and stroke)			
Orthopaedic conditions (fractured neck of femur, hip and knee replacements)			
Falls			
Degenerative long term conditions (rheumatoid Arthritis, muscular dystrophy,Parkinsons)			
Learning disability			
Frailty			
Major depression			
Bipolar disorder (manic depression)			
Schizophrenia/Schizoaffective disorder			
Post-Traumatic Stress Disorder			

Obsessive-compulsive disorder			
Personality disorders /complex emotional needs			
Eating disorders			
Dementia/Alzheimer			
Other			

Q3

ASSESSMENT EXPERIENCE

Please tell us if you ever used any questionnaires or other tools in your Occupational Therapy practice practice to assess the following below by replying **Y** or **N** in the appropriate column. If yes, please state which tools/questionnaires you have used. Please use the comments column to tell us any additional information

Assessment tools	Yes / No	If yes, please insert which tools you have used	Comments
Symptoms of mental illness			
Needs of people with mental health problems			
Risks (to self or others) relating to patients' mental state or other factors			
Physical health symptoms			
Cognitive impairment			
Learning disability			

Neurological impairment			
Functional decline			
Other			

Q4

PHYSICAL AND MENTAL HEALTH INTERVENTIONS EXPPERIENCE

Please indicate your experience in delivering interventions by replying **Y** or **N** in the appropriate column. If yes, please state approximately how many years' experience you have had. Please use the comments column to tell us any additional information.

Interventions	Yes / No	If yes, approximate numbers of years	Comments
Functional assessment of patient presentation			
Rehabilitation needs assessment and intervention planning			
Moving and Handling assessment and recommendation			
Assessment and provision of equipment			
Assessment and recommendation for minor or major home adaptations			

Falls assessment and intervention			
Cognitive Behavioural Therapy			
Sensory Integration			
Recovery interventions			
Family therapy or family-based interventions			
Mindfulness			
Counselling			

Q5

AGE-SPECIFIC EXPERIENCE

Please indicate your experience with working in the following age ranges by replying **Y** or **N** in the appropriate column. If yes, please state approximately how many years' experience you have had. Please use the comments column to tell us any additional information

Age Experience	Yes / No	If yes, approximate numbers of years	Comments
School age (ages 6-12 years)			
Adolescents (ages 12-18 years)			
Adults (ages 18-65 years)			
Older adult (ages 65 +)			

Q6

ANY OTHER INFORMATION

Please share any other information which may be relevant to working with people with physical and mental health problems

THANK YOU