The Child Development Network

Questionnaire for Parents
Dr Catherine Skellern

Your Child’s Name

Preschool / Daycare / Kindergarten

How long has he/she been there?

Mother’s Name

Father’s Name

If separated please indicate (✔)

☐ If you are separated, we will need to discuss the arrangements with you.

What does your child enjoy, do well, and what do you like about them?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
Overall, how concerned (worried) are you about your child?

Not at all    A little    Moderately    Quite a lot    Extremely

Mother  1  2  3  4  5
Father  1  2  3  4  5

What concerns you, and what don’t you understand about your child?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

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________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
What would you like from us?

______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
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Your child's health (✔)

Any concerns about your child’s health currently? □ Yes □ No
Any concerns about the pregnancy? □ Yes □ No
Any concerns about the birth and postnatal period? □ Yes □ No
Any accidents / injuries / serious illnesses in the past

Has your child’s hearing been checked? □ Yes □ No
If it has been checked, was it normal? □ Yes □ No
Has your child’s vision been checked? □ Yes □ No
Is your child fully immunised? □ Yes □ No
Are there any other important medical issues? □ Yes □ No

What was the birth weight? _________
If premature, how many weeks? _________
**As your child was growing up, were you concerned about (✓)**

<table>
<thead>
<tr>
<th>Concern</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>The first year? (e.g. hard to settle, poor weight gain?)</td>
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<tr>
<td>Early motor development (sitting, walking, running, kicking)?</td>
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<td>Early language (talking and understanding)?</td>
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<td>Early social development (eye contact, play, friends)?</td>
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<td>Early learning (e.g. colours, shapes, drawing)?</td>
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<td>Any other major concerns during early childhood?</td>
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**The Family (✓)**

Does anybody in the family (siblings, parents, grandparents, aunts, etc) have problems **similar** to, or the **same as** your child? □ Yes □ No

Does anybody in the family (siblings, parents, grandparents, aunts, etc) have **different** problems, of a developmental, learning, behavioural, emotional or psychiatric nature? □ Yes □ No

**Of any problems identified above, what in particular would you like to discuss?**

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

______________________________________________

Dr Catherine Skellern– Initial Parent Questionnaire (Preschool)
Who have you consulted for your child’s difficulties?
(Remember to bring a copy of all written reports!)

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<thead>
<tr>
<th></th>
<th>Current [✔]</th>
<th>In the Past [✔]</th>
<th>Who?</th>
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<tbody>
<tr>
<td><strong>Health Services</strong></td>
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<tr>
<td>Paediatrician</td>
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<td>Child Psychiatrist</td>
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<tr>
<td>Occupational Therapist</td>
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<tr>
<td>Physiotherapist</td>
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<td>Speech Pathologist</td>
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<td>Psychologist</td>
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<tr>
<td>Social Worker / Counselor</td>
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<td><strong>Education Services</strong></td>
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<tr>
<td>School Guidance Officer</td>
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<tr>
<td>Support / Remedial Teacher</td>
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<td>Home Tutor</td>
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<td><strong>Other</strong></td>
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</table>

Who is your GP? ____________________________

For any professionals identified, please summarise the involvement. (When it started / ceased, how often, what was done)
__________________________________________________________________________________________________________________________________________
__________________________________________________________________________________________________________________________________________
__________________________________________________________________________________________________________________________________________
__________________________________________________________________________________________________________________________________________
__________________________________________________________________________________________________________________________________________

**When you come to see us**

Is there sensitive information that you would prefer not to talk about in front of your child? □ Yes □ No

If yes, we can discuss these issues while the child waits outside.
You may wish to bring a book or something for them to do while they wait.
If they will need supervision, please bring somebody along to supervise them.

Thank you for taking the time to complete this questionnaire.
Completed by ______________________

Date ______________