Heather McAuliffe
General Psychologist
Clinical Psychologist Registrar
MClinPsych, MProfPsych, BPsych (Hons)

Assessment Questionnaire

The following questionnaire is designed to assist with gathering information to understand your young persons' unique circumstances. Please be as detailed as possible.

Child's name:_____ **DOB:** _____ **Age:**_____ **Sex:** _____

Person completing questionnaire & relationship to child:_____

Today's date: _____

Family members and household/s composition:

Name	*Relationship*	*Occupation*	*Age*

Are there any legal proceedings currently occurring? ☐Yes ☐No. If yes, please provide details:

_____

_____

_____

_____

Custody arrangements if applicable:

_____

_____

Is your child currently under the care of other professionals at the Child Development Network?

☐Yes ☐ No If yes, who?

_____

_____

_____

_____

Describe your major concerns about your young person at this present time.

When were these concerns first noticed?

Please describe your child's strengths:

What activities does your child most like to spend their time doing? Please describe any special skills or areas of particular interest in as much detail as possible.

Please list your child's least favourite activities:

How does your young person respond to sensory input and changes in their surroundings, including any preferences or aversions?

Technology:

Please list any devices such as mobile phones, tablets, or gaming consoles your child has access to:

How many days per week does your child have access to devices and/or gaming? _____

How many hours per day does your child average playing on devices or gaming? _____

Do you experience any problems if restrictions are placed on access to devices or gaming? If yes, please provide details:

Developmental History:

Were there any concerns or difficulties during pregnancy? ☐Yes ☐ No If yes, please describe:

_____

_____

Was the birth mother taking any medications during pregnancy? ☐Yes ☐ No If yes, please describe:

_____

_____

Term length: □ Full term □ Premature _____(weeks) □ Late ____ (weeks)

Birth weight:_____

Any complications ***during*** birth? If yes, please describe:

_____

_____

Did your child experience any complications ***following*** birth? If yes, please describe:

_____

_____

The following is a list of infant and early childhood developmental milestones. Please indicate the approximate age when your child was able to do the following:

Behaviour	**Age**	**Behaviour**	**Age**
Showed response to parent	_____	Dressed self	_____
Rolled over	_____	Fed Self	_____
Crawled	_____	Rode bicycle	_____
Babbled	_____	Toilet trained – daytime	_____
Sat unaided	_____	– nighttime	_____
Spoke several words together	_____		_____

Parenting Styles:

There is a lot of pressure to be the "best" parent, but there are many different styles of parenting. Describe your approach to parenting including expectations of your young person, how conflict/boundary setting is managed, and reward systems.

_____

_____

_____

_____

_____

_____

_____

Social and Emotional Development:

Please tick if you currently observe/have concerns for any of the following:

____ Differences in Communication	____ Easily frustrated / Angers quickly
____ Preferring to play alone	____ Frequent nightmares
____ Does not get along well with siblings	____ Difficulties sleeping
____ Does not get along well with peers	____ Eats poorly
____ Aggressive behaviour	____ Frequently in trouble at home/school
____ Is shy or timid	____ Avoids things that cause anxiety
____ Is more interested in objects than people	____ Intense interests
____ Engages in dangerous behaviours	____ Fixated on gaming or technology
____ Has particular fears	____ Poor behaviour if gaming not available
____ Soils self or their bed	____ Avoids / refuses school

Education:

What schools or educational facilities has your child attended? Please list all below:

1. Daycare: _____
2. Kindergarten: _____
3. Primary School: _____
4. High School: _____

Please list any difficulties your young person has experienced since commencing their formal education Eg. Separation anxiety at drop off, learning difficulties, social difficulties.

_____

_____

_____

Has your child been given any additional supports at school. □ Yes □ No.
If yes, please provide details.

_____

_____

_____

_____

Is your child achieving at or above the expected level in their most recent school report?
□ Yes □ No.
If no, please list what areas they are experiencing difficulty with?

_____

_____

_____

Medical History:

Does your child have any current medical diagnosis? ☐Yes ☐
No If yes, please provide details.

_____

_____

_____

Does your child take any medications? □ Yes □

No. If yes, please list medications and reasons.

_____

_____

_____

Has your child previously experienced any serious illnesses or injury? □ Yes □ No.

If yes, please provide details.

_____

_____

_____

Is there any suspected or formally diagnosed family history of psychological, developmental or learning differences? □ Yes □ No.

If yes, please provide details including whether suspected/self-identified or formally diagnosed.

_____

_____

_____

_____

_____

_____

Treatment History:

Have you previously consulted a professional for psychological or behavioural concerns?

☐ Yes ☐No

If yes, please provide details including any diagnosis that have previously been given.

_____

_____

_____

Has your child previously or currently accessing other allied health treatments outside of CDN?

Eg. Speech pathology, occupational therapy? ☐Yes ☐No.

If yes, please provide details.

_____

_____

_____

What treatment approaches have you previously found helpful or unhelpful? Please provide details.

_____

_____

Is there anything else relevant to your child or family circumstances that I should be made aware of?

☐ Yes ☐ No

If yes, please provide details below.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Thank you for your time.