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:

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Occupation</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>Age</th>
<th>Behaviour</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Showed response to parent</td>
<td></td>
<td>Dressed self</td>
<td></td>
</tr>
<tr>
<td>Rolled over</td>
<td></td>
<td>Fed Self</td>
<td></td>
</tr>
<tr>
<td>Crawled</td>
<td></td>
<td>Rode bicycle</td>
<td></td>
</tr>
<tr>
<td>Babbled</td>
<td></td>
<td>Toilet trained – daytime</td>
<td></td>
</tr>
<tr>
<td>Sat unaided</td>
<td></td>
<td>– nighttime</td>
<td></td>
</tr>
<tr>
<td>Spoke several words together</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.