Questionnaire for Parents

Dr Rebecca Kriukelis

Your Child's Name _____

Preschool/ Daycare/ Kindergarten _____

How many days a week do they attend? _____

How long has he/she been there? _____

Parent/Guardian 1 Name _____

Occupation _____

Parent/Guardian 2 Name _____

Occupation _____

If separated please indicate (☐) ☐ If you are separated, we will need to discuss the arrangements with you.

Siblings

Name	Age	Relationship	Live in the house (✓)

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(07) 3369 3369 (07) 3369 3370 www.cd.net.au cdn@cd.net.au

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
Parent/Guardian 1	1	2	3	4	5
Parent/Guardian 2	1	2	3	4	5

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

What would you like from us?

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	□ Yes	□ No
Has your child's hearing been checked?	□ Yes	□ No
It 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 (□)

The first year? (e.g. hard to settle, poor weight gain?)	□ Yes	□ No
Early motor development (sitting, walking, running)	□ Yes	□ No
Early language (talking and understanding)?	□ Yes	□ No
Early social development (eye contact, play, friends)?	□ Yes	□ No
Early learning (e.g. colours, shapes, drawing)?	□ Yes	□ No
Any other major concerns during early childhood?	□ Yes	□ No

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

For anything identified above, is there anything in particular that you would like to discuss?

Who have you consulted for your child's difficulties?

(Please remember to bring a copy of all written reports to your appointment)

	Currently [✓]	In the past [✓]	Who?
Health Service			
Paediatrician			
Child Psychiatrist			
Speech Pathologist			
Occupational Therapist			
Physiotherapist			
Psychologist			
Social Worker/Counsellor			
Education Services			
Educators			
ECDP			
Other (eg Naturopath)			

Who is your GP?

_____

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

_____

_____

_____

_____

_____

_____

When you come to see us:

Is there any sensitive information that you would prefer to not 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.

Completed by _____

Date _____

Thank you for taking the time to complete this questionnaire.