

## Questionnaire for Parents Dr Rebecca Kriukelis

**Your Child's Name**

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**Name of current school?**

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**Current year level at school?**

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**How long has he/she been there?**

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**Parent/Guardian 1 Name**

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**Occupation**

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**Parent/Guardian 2 Name**

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**Occupation**

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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 (✓)

 19 Lang Parade, Milton 4064

 PO Box 1536, Milton 4064

 (07) 3369 3369

 (07) 3369 3370

 [www.cd.net.au](http://www.cd.net.au)

 [cdn@cd.net.au](mailto:cdn@cd.net.au)

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

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**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?**

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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  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?**

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**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?
<b>Health Service</b>			
Paediatrician			
Child Psychiatrist			
Speech Pathologist			
Occupational Therapist			
Physiotherapist			
Psychologist			
Social Worker/Counsellor			
<b>Education Services</b>			
School Guidance Officer			
Support/ Remedial Teacher			
Home Tutor			
<b>Other</b> (eg Naturopath)			

**Who is your GP?**

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**For any professionals identified, please summarise their involvement.**

(When it started / ceased, how often, what was done)

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**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.