



**Child
Development
Network**

The Child Development Network

Questionnaire for Parents

Dr Aarany Sivakaanthan

Your Child's Name

Current school

How long has your child been there?

What grade is your child in currently?

Parent/Guardian 1 Name

Parent/Guardian 2 Name

If separated please indicate (✓)

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

Parent/Guardian 1 Occupation

Parent/Guardian 2 Occupation

Siblings

Name	Age	Relationship	Live in house? (✓)
			()
			()
			()
			()
			()

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
- 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 (✓)

- The first year? (e.g. hard to settle, poor weight gain?) Yes No
- Early motor development (sitting, walking, running, kicking)? 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, uncles etc) have problems **similar** to, or the **same as** your child? Yes No

Does anybody in the family (siblings, parents, grandparents, aunts, uncles 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?

Who have you consulted for your child's difficulties?

(Remember to bring a copy of all written reports!)

	Currently (✓)	In the Past (✓)	Who?
Health Services			
Paediatrician			
Child Psychiatrist			
Occupational Therapist			
Physiotherapist			
Speech Pathologist			
Psychologist			
Social Worker / Counselor			
Education Services			
School Guidance Officer			
Support / Remedial Teacher			
Home Tutor			
Other			

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

Sensitive information

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.

Photography Consent

On occasion, we may take a photo of your child to help us remember them, and this photo may be stored on our computer system. Yes No
Do you or your child have any object to this?

Information from Third Parties

Sometimes we require information from third parties such as school teachers, other health professionals, and people that interact with your child.
Do we have your permission to contact these third parties? Yes No

Completed by _____ Date _____

Thank you for taking the time to complete this questionnaire.