



The Child Development Network

# Questionnaire for Parents Holly Kennedy

## Your Child's Name

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Preschool / Daycare / Kindergarten

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How long has your child been there?

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How many days a week do they attend?

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## Parent/Guardian 1 Name

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## Parent/Guardian 2 Name

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If separated please indicate (✓)

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

## Parent/Guardian 1 Occupation

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## Parent/Guardian 2 Occupation

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## Siblings

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

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**Who have you consulted for your child's difficulties?**

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

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

**Who is your GP?**

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

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## 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 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.*