Child Development Network

Parent Questionnaire
Preschool/Daycare/Kindergarten
Dr Keita Hada

Child's Name _____ **DOB** _____

Today's Date _____ Date of CDN Appointment _____

Preschool/Daycare/Kindergarten _____

How many days a week do they attend? _____

How long have they 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 correspondence arrangements with you.

Siblings

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

Level 2, 19 Lang Pde, Milton, 4064 PO Box 1536, Milton 4064

(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
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)?	☐ 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 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 Services			
Paediatrician			
Child Psychiatrist			
Speech Pathologist			
Occupational Therapist			
Physiotherapist			
Psychologist			
Social Worker / Counselor			
Education Services			
Educators			
ECDP			
Other (e.g., Naturopath)			

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 need supervision, please bring somebody along to supervise them.

Completed by _____ **Date** _____

Thank you for taking the time to complete this questionnaire.