

Child's Name _____ **DOB** _____

Today's Date _____ Date of CDN Appointment _____

Current School _____

How long has your child been there? _____

What grade is your child in currently? _____

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? (✓)
			()
			()
			()
			()
			()

Your child's health (✓)

- | | | |
|---|------------------------------|-----------------------------|
| Any concerns about your child's health currently ? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any concerns about the pregnancy? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any concerns about the birth and postnatal period? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any accidents / injuries / serious illnesses in the past? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Has your child's <u>hearing</u> been checked? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If it has been checked, was it normal? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Has your child's <u>vision</u> been checked? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Is your child fully immunised? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are there any other important medical issues? | <input type="checkbox"/> Yes | <input type="checkbox"/> 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)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Early motor development (sitting, walking, running)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Early language (talking and understanding)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Early social development (eye contact, play, friends)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Early learning (e.g. colours, shapes, drawing)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any other major concerns during early childhood? | <input type="checkbox"/> Yes | <input type="checkbox"/> 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

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 Services			
Paediatrician			
Child Psychiatrist			
Speech Pathologist			
Occupational Therapist			
Physiotherapist			
Psychologist			
Social Worker / Counselor			
Education Services			
School Guidance Officer			
Support / Remedial Teacher			
Home Tutor			
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.