The Child Development Network

Questionnaire for Parents

Dr Catherine Skellern

Your Child's Name _____

Preschool / Daycare / Kindergarten _____

How long has your child been there? _____

How many days a week do they attend? _____

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? (✓)
			( )
			( )
			( )
			( )
			( )

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, 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 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.
Do you or your child have any object to this? ☐ Yes ☐ No

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.