

Your Child’s Name

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? (✓)
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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)? 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.