Your Child’s Name

Preschool / Daycare / Kindergarten

How long has your child been there?

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

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**

<table>
<thead>
<tr>
<th>Concern</th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>The first year? (e.g. hard to settle, poor weight gain?)</td>
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<td></td>
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<tr>
<td>Early motor development (sitting, walking, running, kicking)?</td>
<td></td>
<td></td>
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<tr>
<td>Early language (talking and understanding)?</td>
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<tr>
<td>Early social development (eye contact, play, friends)?</td>
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<tr>
<td>Early learning (e.g. colours, shapes, drawing)?</td>
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<td>Any other major concerns during early childhood?</td>
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</table>

**The Family**

Does anybody in the family (siblings, parents, grandparents, aunts, uncles etc) have problems similar to, or the same as your child?

Does anybody in the family (siblings, parents, grandparents, aunts, uncles etc) have different problems, of a developmental, learning, behavioural, emotional or psychiatric nature?

**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!)

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

**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 will 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 □ Yes
stored on our computer system.  □ 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

*Thank you for taking the time to complete this questionnaire.*

**Completed by ________________________    Date ___________________**