



# Questionnaire for Parents Dr Ruth Surman

## Your Child's Name

\_\_\_\_\_

Current school

\_\_\_\_\_

How long has your child been there?

\_\_\_\_\_

What grade is your child in currently?

\_\_\_\_\_

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





## 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?**

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**Who have you consulted for your child's difficulties?**

(Remember to bring a copy of all written reports!)

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

**Who is your GP?**

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

**Completed by** \_\_\_\_\_ **Date** \_\_\_\_\_