CHILD AND FAMILY QUESTIONNAIRE (OP43)

UR No:_____
SURNAME:_____
GIVEN NAME: _____
DOB:_____

ATTACH LABEL IF AVAILABLE

ABOUT THIS FORM:

Why have I been asked to fill out this form?

You have this form because your child has an appointment at Warrnambool Community Health.
The information will help our Child Health and Development Team get to know your child.

Do I need to complete this form?

No, you don't have to fill in the form if you don't want to or have already filled out before, but it helps us get to know you better, and any problems you are facing with how your child is developing and growing.
It is OK if there are things that you can't remember or don't know.
It is OK to skip sections if they are not relevant to your child.
If you would like help filling out this form, you can call us, and we will help you - 5563 4000.

How do I return this questionnaire?

Bring it with you to your first appointment or email it to childhealthanddevelopment@swh.net.au

PERSON WHO IS COMPLETING THIS FORM:

Full name:
Relationship to child (Parent/ Guardian/Carer/Friend…):

GENERAL INFORMATION:

Child's Full Name:	Date of birth :
Address:	
Indigenous Status: Aboriginal ☐ Torres Strait Islander ☐ Neither ☐ Declined to Answer ☐	
Parent/Carer 1 Full Name:	
Address:	
Phone (home):	Phone (mobile)
Email:	Can we contact you via email? Yes ☐ No ☐
Parent/Carer 2 Full Name:	
Address:	
Phone (home):	Phone (mobile)
Email:	Can we contact you via email? Yes ☐ No ☐
Languages Spoken at Home:	
Do you need an interpreter?: Yes ☐ No ☐	Language:

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FAMILY'S CONCERNS:
What are the main concerns you have about your child at present?
Has anyone else expressed concerns about your child's health or development?
Has your child ever been diagnosed with a medical or developmental problem? Please give details.

WHO LIVES WITH YOUR CHILD:		
Adults:		
Name		Relationship to child
Other Children:		
Name	Age	Relationship to child
Are there any family court orders or parenting orders in place? Please provide details		
Have you ever had involvement with Child Protection? Please provide details		

CHILD CARE, KINDER AND SCHOOL ACTIVITIES:				
Where does your child attend?				
	Name of Centre	Days/Times	Main Worker/ Teacher	Can we contact them? ✓
Child Care				☐
3-Year Old Kinder				☐
4-Year Old Kinder				☐
School				☐
What other activities does your child do? (eg: playgroup, swimming, dancing, gym…)				

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OTHER SERVICES YOUR CHILD SEES:		
	Name	Can we contact them? Please tick ✓
Family Doctor		☐
Maternal and Child Health Nurse		☐
Paediatrician		☐
Speech Pathologist		☐
Occupational Therapist		☐
Physiotherapist		☐
Dietitian		☐
Counselling/ Social Worker		☐
Family Support Worker (eg:)		☐
Early Childhood Intervention Services (eg: Mpower, Gateways, Child First, Cradle to Kinder, mpower, council		☐

GENERAL HEALTH

How would you describe your child's general health?

Are immunisations up to date? Yes ☐ No ☐

Does your child have any diagnosed allergies or asthma? Yes ☐ No ☐
Details:

Do they have treatment or medications?

Has your child ever had a serious accident, or a serious illness or infection? Yes ☐ No ☐
Details:

Has your child ever been in hospital? Yes ☐ No ☐
Details:

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HEARING AND VISION:		
Does your child get lots of ear infections?		
Have they ever seen an Ear Nose and Throat doctor, or have they ever had grommets? Please give details.		
Has your child's hearing ever been tested?		
Where:	Date:	Results:
Has your child's vision ever been tested?		
Where:	Date:	Results:

PREGNANCY: (If you are not the birth mother, please tell us as much as you can)
Did you have any health problems during your pregnancy (eg: complications, illness, pre-eclampsia, diabetes…)
Did you need any treatment or support during your pregnancy?
Did you take any presciption medicines during your pregnancy? Please give details:
Did you take any non-prescription drugs or drink alcohol during your pregnancy? If you are happy to, please tell us more information. It is important to know, when helping your child:
Did you or your partner feel down or depressed either before or after your child was born? If yes, what help or support did you get?

YOUR CHILD'S BIRTH:	
Born at:_____ weeks	Birth weight: _____
Were there any complications during or just after the birth (eg: emergency caesarian, breech birth, Special Care Nursery, oxygen, tube feeding?)Please give details.	

FEEDING, EATING AND GROWTH:
How was you child fed as a baby? Breast ☐ Bottle ☐ Tube ☐ Combination ☐ For how long?
When did your baby start eating solids?

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Did your child have any feeding or swallowing problems as a baby? Please give details.

How does your child eat now? Fed by an adult ☐ With their hands ☐ Spoon/fork ☐

Are you worried about your child's eating now? (do they eat different types of foods and textures? Are mealtimes stressful?) Please give details.

Has your child lost weight lately? Yes ☐ No ☐
Has your child had poor weight gain over the past few months? Yes ☐ No ☐
Has your child been eating /feeding less in the last few weeks? Yes ☐ No ☐
Is you child obviously underweight? Yes ☐ No ☐
(If "yes to two or more, consider referral to Dietitian)

Are you concerned about your child's growth? Please give details.

Are you concerned with the variety of foods your child Eats? (e.g Fruit, Vegetables, Dairy, Meat / protein/ legumes, fats/oils, nuts, grains and carbohydrates). Descibe typical meals and times.

PERSONALITY AND BEHAVIOUR:

Describe your child's personality?

What are your child's strengths, and things they do well?

How easy is it to manage your child's behaviour? Easy ☐ Average ☐ Difficult ☐
Please give examples.

Do you have any worries about your child's behaviour (eg: tantrums, cooperation, getting along with others)

Describe your child's activity levels (eg: withdrawn, busy, hyperactive)

How well does your child make friends, and get on with other people? Please give examples.

Is there anything your child doesn't like, or avoids? (eg: loud noises, messy hands, sand, tags on clothes…)

Does your child do any behaviours repeatedly? (eg: spinning, turning switches on and off, watching the same movie…)

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PLAY AND LEARNING :
What type of play does your child enjoy the most? (eg: playing alone, rough & tumble, outside, pretend play…)
What toys does your child like to play with?
Can your child sit and concentrate on an activity they are interested in? Please give examples.
Do you have concerns about your child's play or learning (eg: attention span, concentration, organising their own play…)

MOVEMENT AND PHYSICAL DEVELOPMENT :

When did your child:

	Age (don't worry if you can't remember exact ages)	Comments
Roll		
Sit alone		
Crawl		
Climb onto a couch or parent		
Walk without help		

Are you worried about your child's physical development (eg: balance, coordination, strength, tripping, running, ball skills, riding a bike)? Please give details.
Are you worried about how your child uses their hands (eg: holding and playing with toys, feeding, holding a pencil, drawing, doing up buttons and shoe laces…)? Please give details.

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SPEECH AND LANGUAGE DEVELOPMENT :		
When did your child:		
	Age (don't worry if you can't remember exact ages)	Comments/ Examples
Babble (eg: bababa, oooh, mumum)		
Point to something they want		
Say first words		
Join words together (eg: more juice, my daddy)		
Do you think your child understand what people say to them? Can your child follow simple instructions? (eg: get your shoes, take the doll to daddy)		
Can your child join in a two-way conversation, taking turns to listen and talk with another person?		
How well does your child use words to get their message across?		
If your child doesn't use many words, how do they get their message across? (eg: pointing, grunting, shouting)		
Does your child say words clearly? If not, please write some examples of what they say.		

DAILY ROUTINES/ SELF CARE SKILLS:
Describe your child's sleep pattern, and naps:
Where is your child up to with toilet training? Nappies day and night ☐ Nappies – only when sleeping ☐ Fully toilet trained ☐
Where is your child up to with self-care (eg: dressing, cleaning teeth, washing, brushing hair…) Needs help always ☐ Starting to become independent ☐ Independent ☐
Describe what you do in a typical day with your child
Does your child get upset if you change their daily routine? Please give examples.

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FAMILY WELLBEING AND RELATIONSHIPS:
Who are the most important people in your child's life (eg: parents, grandparents, friends…)
Are there any family relationship issues that might affect your child? (eg: separation, family violence…)
Does your family have enough support and help to look after your child if things become difficult?
Does your family have any problems with housing or transport? Please give details.

ANYTHING ELSE?
Is there anything else you would like to tell us about?

Signed (Parent/Carer):	Date:
Signed (Staff Member):	Date:

Thank you for filling out this form