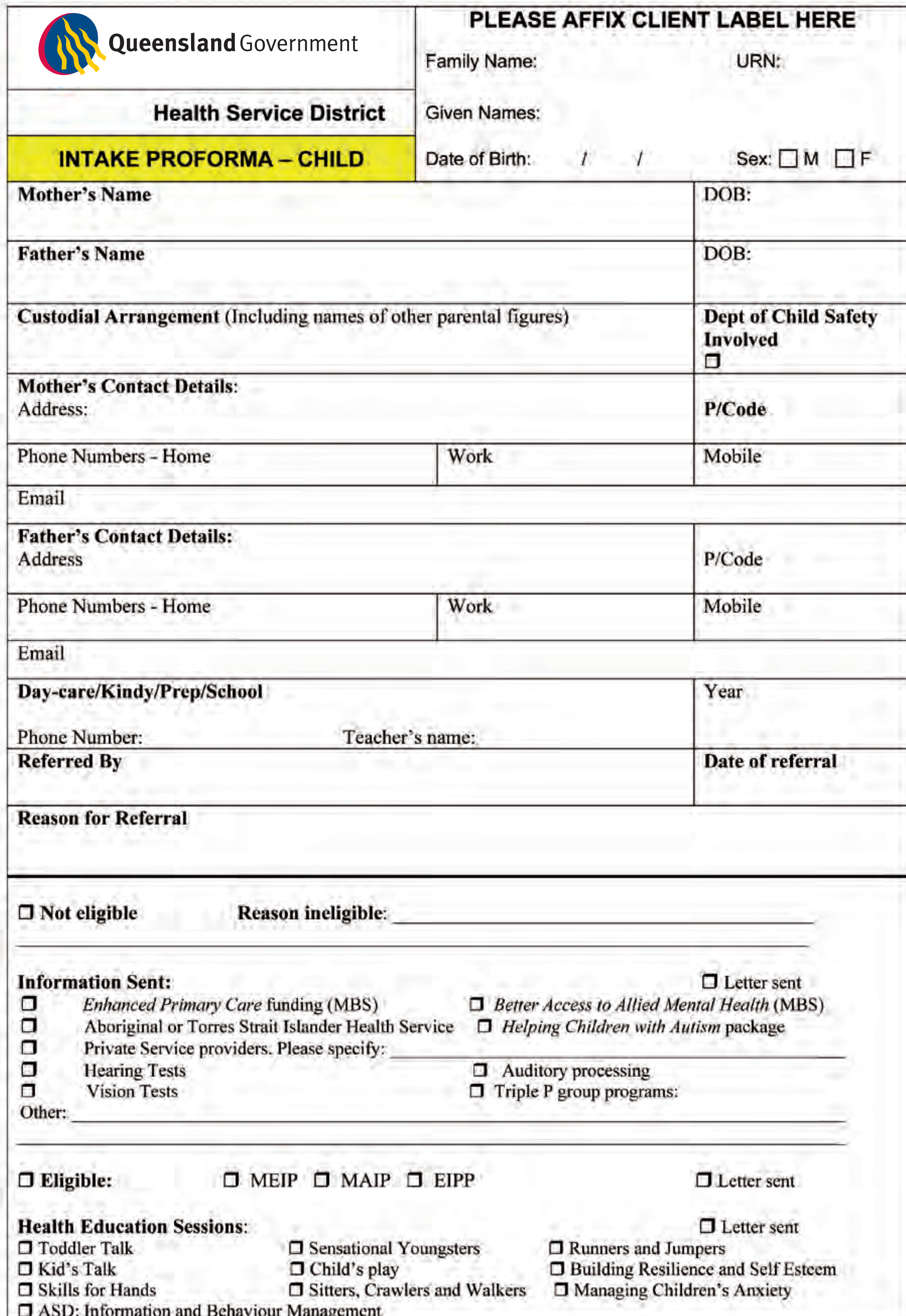


Queensland Government

Health Service District

INTAKE PROFORMA – CHILD

PLEASE AFFIX CLIENT LABEL HERE

Family Name: URN:

Given Names:

Date of Birth: / / Sex: ☐ M ☐ F

Mother's Name		DOB:
Father's Name		DOB:
Custodial Arrangement (Including names of other parental figures)		**Dept of Child Safety Involved** ❒
Mother's Contact Details: Address:		**P/Code**
Phone Numbers - Home	Work	Mobile
Email		
Father's Contact Details: Address		P/Code
Phone Numbers - Home	Work	Mobile
Email		
Day-care/Kindy/Prep/School Phone Number: Teacher's name:		Year
Referred By		**Date of referral**
Reason for Referral		

❒ **Not eligible** **Reason ineligible:** ______________________

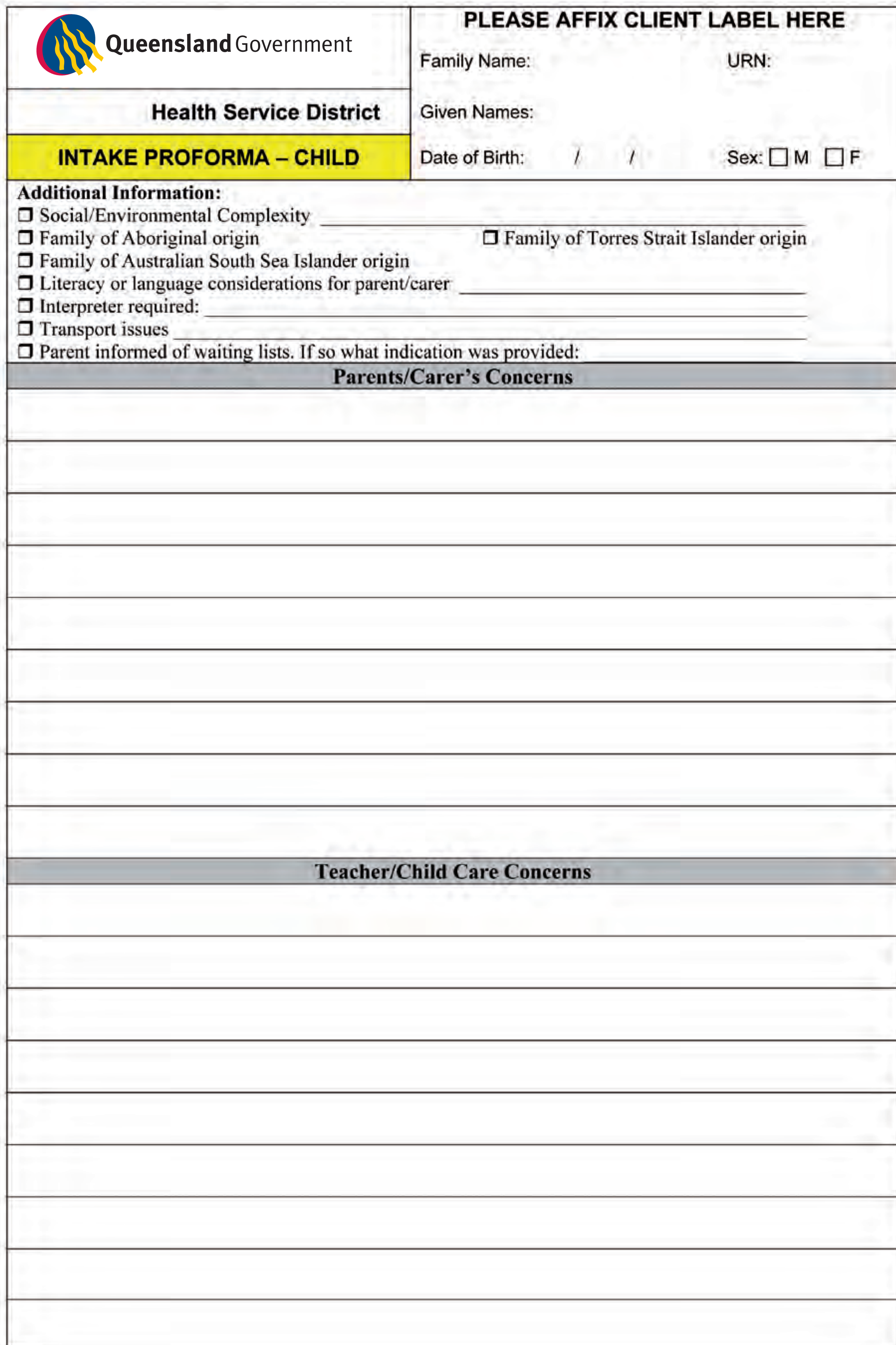
Information Sent: ❒ Letter sent

❒ *Enhanced Primary Care* funding (MBS) ❒ *Better Access to Allied Mental Health* (MBS)
❒ Aboriginal or Torres Strait Islander Health Service ❒ *Helping Children with Autism* package
❒ Private Service providers. Please specify: ______________________
❒ Hearing Tests ❒ Auditory processing
❒ Vision Tests ❒ Triple P group programs:
Other: ______________________

❒ **Eligible:** ❒ MEIP ❒ MAIP ❒ EIPP ❒ Letter sent

Health Education Sessions: ❒ Letter sent

❒ Toddler Talk ❒ Sensational Youngsters ❒ Runners and Jumpers
❒ Kid's Talk ❒ Child's play ❒ Building Resilience and Self Esteem
❒ Skills for Hands ❒ Sitters, Crawlers and Walkers ❒ Managing Children's Anxiety
❒ ASD: Information and Behaviour Management



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Family Name: URN:

Given Names:

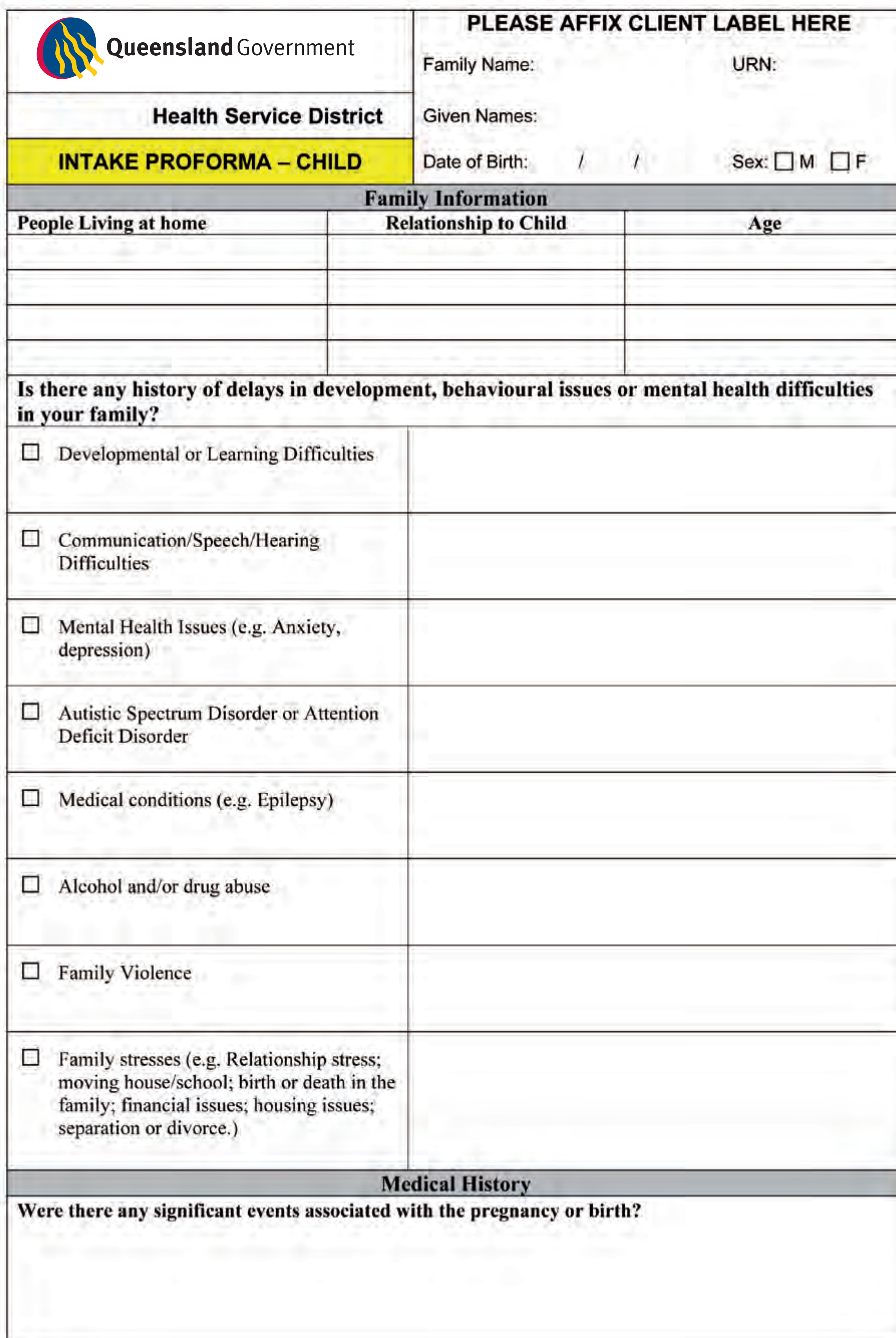
Date of Birth: / / Sex: ☐ M ☐ F

Additional Information:

- ☐ Social/Environmental Complexity ______
- ☐ Family of Aboriginal origin ☐ Family of Torres Strait Islander origin
- ☐ Family of Australian South Sea Islander origin
- ☐ Literacy or language considerations for parent/carer ______
- ☐ Interpreter required: ______
- ☐ Transport issues ______
- ☐ Parent informed of waiting lists. If so what indication was provided:

Parents/Carer's Concerns

Teacher/Child Care Concerns



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Health Service District

INTAKE PROFORMA – CHILD

PLEASE AFFIX CLIENT LABEL HERE

Family Name: URN:

Given Names:

Date of Birth: / / Sex: ☐ M ☐ F

Family Information

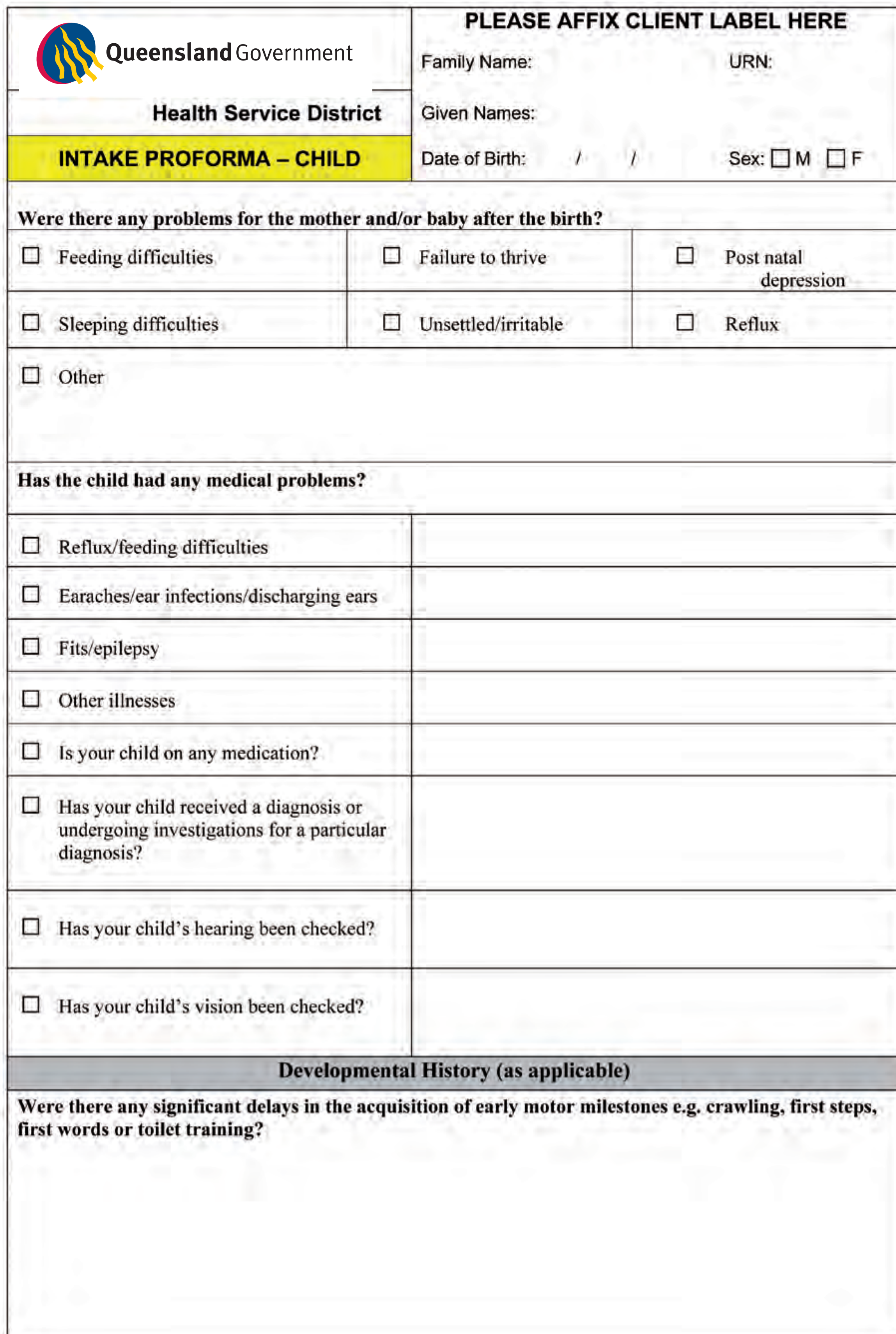
People Living at home	Relationship to Child	Age

Is there any history of delays in development, behavioural issues or mental health difficulties in your family?

☐ Developmental or Learning Difficulties	
☐ Communication/Speech/Hearing Difficulties	
☐ Mental Health Issues (e.g. Anxiety, depression)	
☐ Autistic Spectrum Disorder or Attention Deficit Disorder	
☐ Medical conditions (e.g. Epilepsy)	
☐ Alcohol and/or drug abuse	
☐ Family Violence	
☐ Family stresses (e.g. Relationship stress; moving house/school; birth or death in the family; financial issues; housing issues; separation or divorce.)	

Medical History

Were there any significant events associated with the pregnancy or birth?



Queensland Government Health Service District **INTAKE PROFORMA – CHILD**	**PLEASE AFFIX CLIENT LABEL HERE** Family Name: URN: Given Names: Date of Birth: / / Sex: ☐ M ☐ F

Were there any problems for the mother and/or baby after the birth?

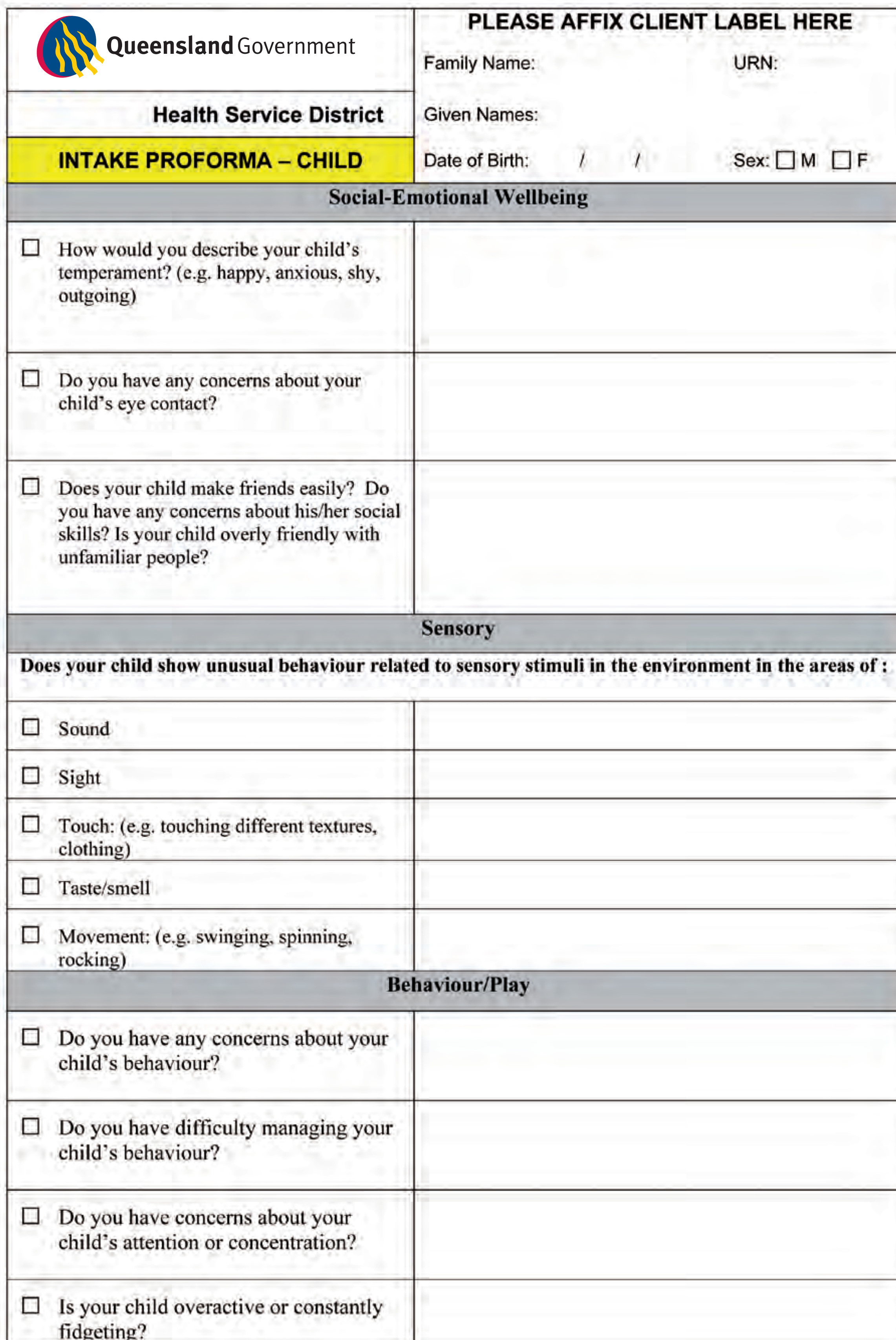
☐ Feeding difficulties	☐ Failure to thrive	☐ Post natal depression
☐ Sleeping difficulties	☐ Unsettled/irritable	☐ Reflux
☐ Other		

Has the child had any medical problems?

☐ Reflux/feeding difficulties	
☐ Earaches/ear infections/discharging ears	
☐ Fits/epilepsy	
☐ Other illnesses	
☐ Is your child on any medication?	
☐ Has your child received a diagnosis or undergoing investigations for a particular diagnosis?	
☐ Has your child's hearing been checked?	
☐ Has your child's vision been checked?	

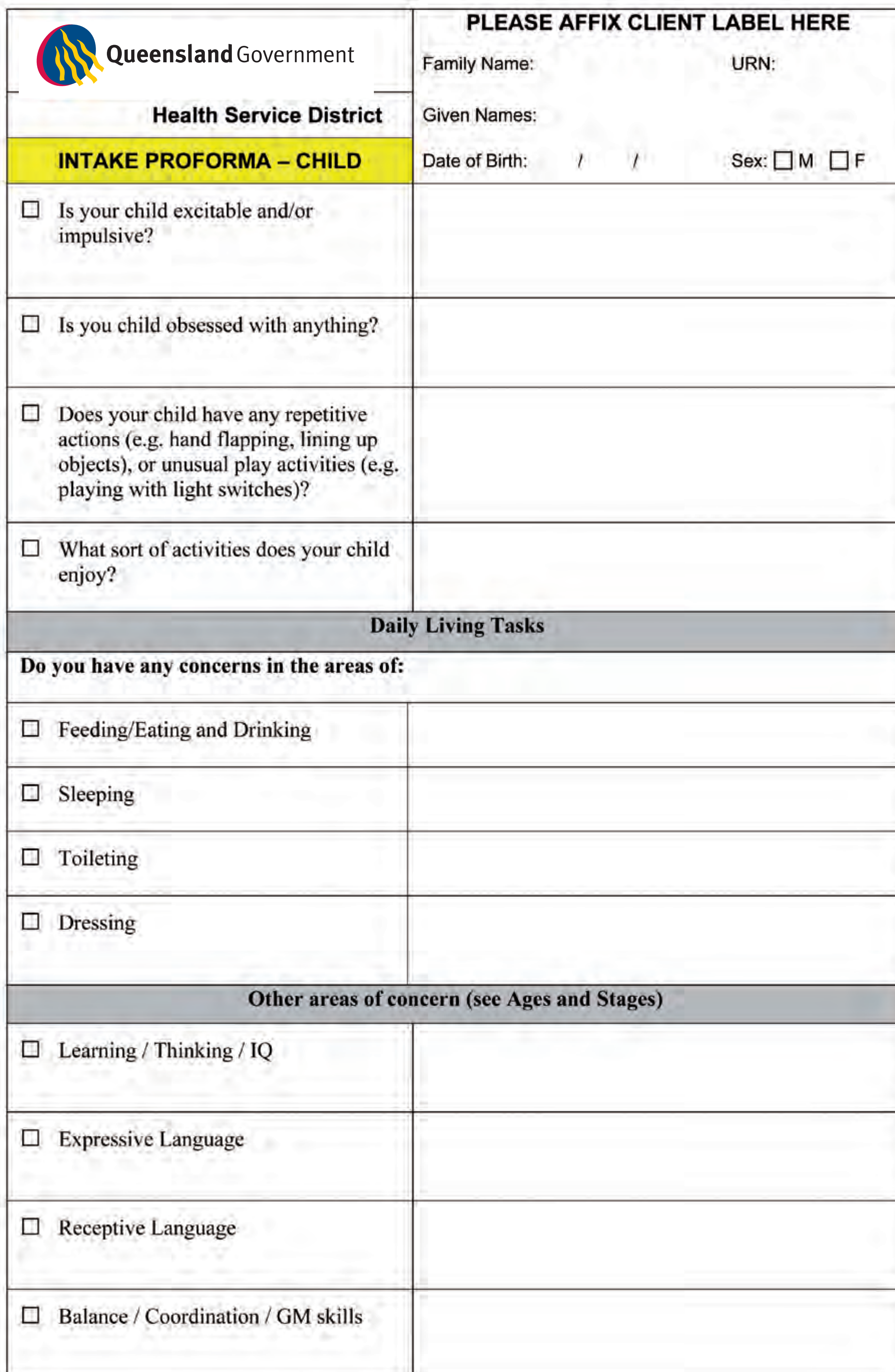
Developmental History (as applicable)

Were there any significant delays in the acquisition of early motor milestones e.g. crawling, first steps, first words or toilet training?

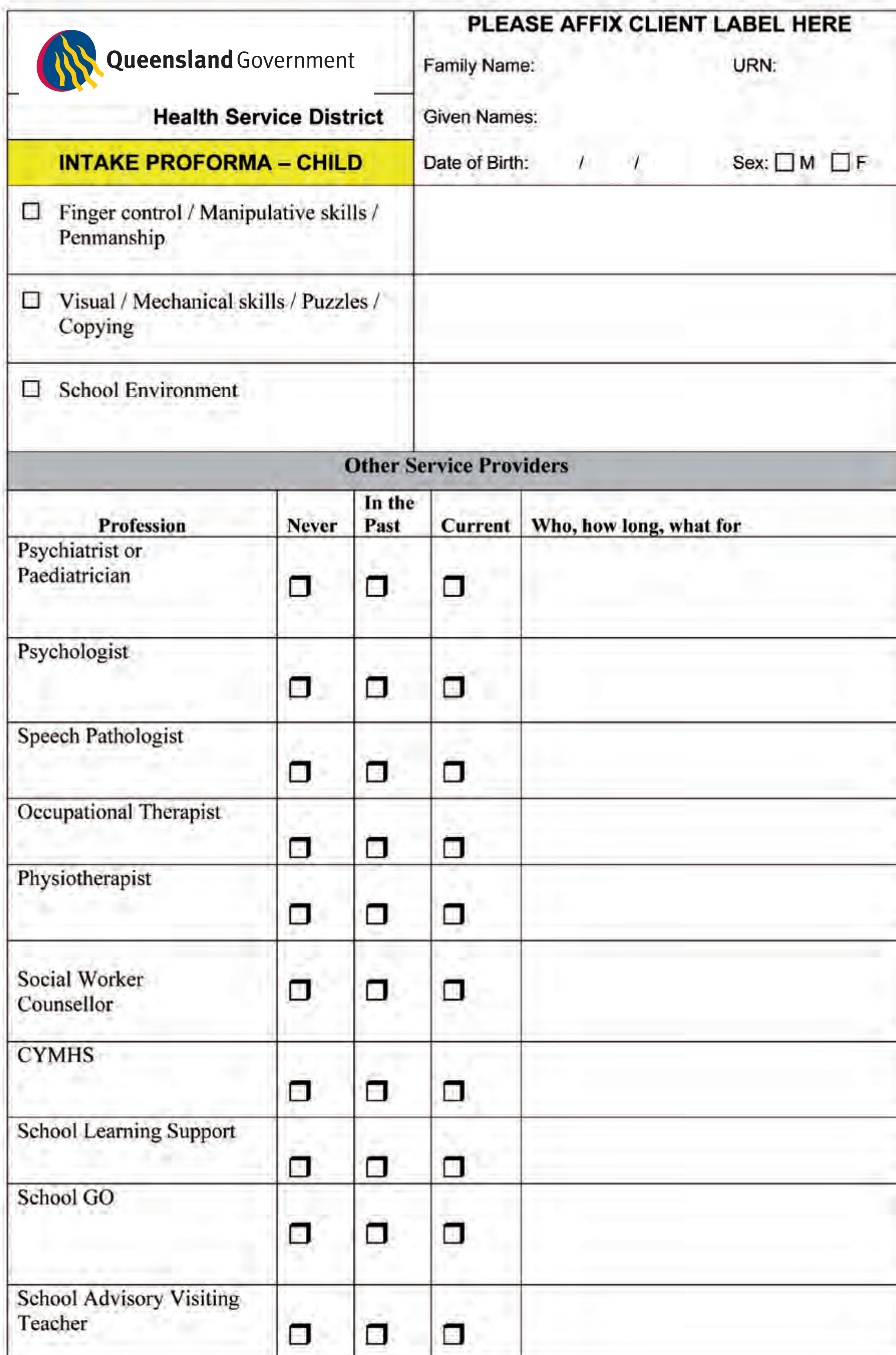


Queensland Government	PLEASE AFFIX CLIENT LABEL HERE Family Name: URN:
Health Service District	Given Names:
INTAKE PROFORMA – CHILD	Date of Birth: / / Sex: ☐ M ☐ F

Social-Emotional Wellbeing	
☐ How would you describe your child's temperament? (e.g. happy, anxious, shy, outgoing)	
☐ Do you have any concerns about your child's eye contact?	
☐ Does your child make friends easily? Do you have any concerns about his/her social skills? Is your child overly friendly with unfamiliar people?	
Sensory	
Does your child show unusual behaviour related to sensory stimuli in the environment in the areas of :	
☐ Sound	
☐ Sight	
☐ Touch: (e.g. touching different textures, clothing)	
☐ Taste/smell	
☐ Movement: (e.g. swinging, spinning, rocking)	
Behaviour/Play	
☐ Do you have any concerns about your child's behaviour?	
☐ Do you have difficulty managing your child's behaviour?	
☐ Do you have concerns about your child's attention or concentration?	
☐ Is your child overactive or constantly fidgeting?	



Queensland Government Health Service District **INTAKE PROFORMA – CHILD**	**PLEASE AFFIX CLIENT LABEL HERE** Family Name: URN: Given Names: Date of Birth: / / Sex: ☐ M ☐ F
☐ Is your child excitable and/or impulsive?	
☐ Is you child obsessed with anything?	
☐ Does your child have any repetitive actions (e.g. hand flapping, lining up objects), or unusual play activities (e.g. playing with light switches)?	
☐ What sort of activities does your child enjoy?	
Daily Living Tasks	
Do you have any concerns in the areas of:	
☐ Feeding/Eating and Drinking	
☐ Sleeping	
☐ Toileting	
☐ Dressing	
Other areas of concern (see Ages and Stages)	
☐ Learning / Thinking / IQ	
☐ Expressive Language	
☐ Receptive Language	
☐ Balance / Coordination / GM skills	



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Health Service District

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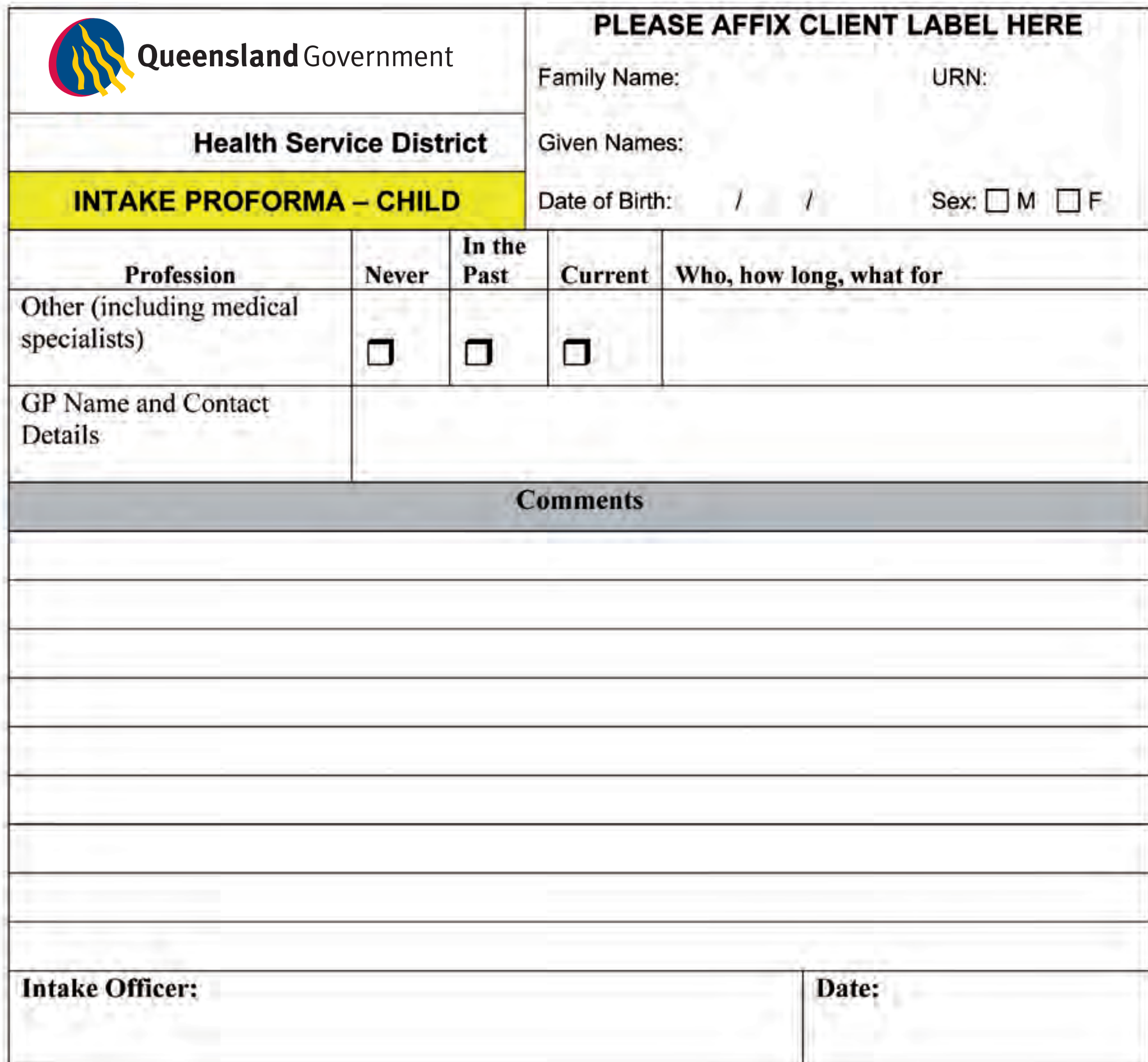
Given Names:

Date of Birth: / / Sex: ☐ M ☐ F

☐ Finger control / Manipulative skills / Penmanship	
☐ Visual / Mechanical skills / Puzzles / Copying	
☐ School Environment	

Other Service Providers

Profession	Never	In the Past	Current	Who, how long, what for
Psychiatrist or Paediatrician	☐	☐	☐	
Psychologist	☐	☐	☐	
Speech Pathologist	☐	☐	☐	
Occupational Therapist	☐	☐	☐	
Physiotherapist	☐	☐	☐	
Social Worker Counsellor	☐	☐	☐	
CYMHS	☐	☐	☐	
School Learning Support	☐	☐	☐	
School GO	☐	☐	☐	
School Advisory Visiting Teacher	☐	☐	☐	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Health Service District

INTAKE PROFORMA – CHILD

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Family Name: URN:

Given Names:

Date of Birth: / / Sex: ☐ M ☐ F

Profession	Never	In the Past	Current	Who, how long, what for
Other (including medical specialists)	☐	☐	☐	
GP Name and Contact Details				

Comments

Intake Officer:	Date: