



Queensland Government

Child Development Parent/Caregiver Questionnaire

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth:

Sex: M F I

A word to parents

If you have been asked to complete this by your child's teacher in preparation for a GP review, please take it with you to the appointment to inform the GP's assessment of your child.

If this information was directly requested by Sunshine Coast Hospital and Health Service, please return it to the appropriate address at the bottom of the last page.

The child's details

You child's name: Sex: Male Female

Date of birth: .. / .. / Year level at school:

School attended:

Parent information

Your name: Relationship to child:

Date questionnaire completed: .. / .. / Phone:

Email address: Your signature:

Your child's strengths and difficulties

What does your child do well and what do they enjoy?

.....
.....
.....
.....
.....
.....

What are the main concerns you have about your child and what would you like assistance with?

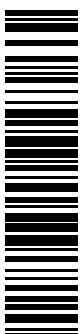
.....
.....
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.....

OVERALL, please indicate what level of difficulty you feel your child is experiencing in the following areas:

- | | | | | |
|----------------|-------------------------------|-------------------------------|-----------------------------------|---------------------------------|
| Educational: | <input type="checkbox"/> None | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| Behavioural: | <input type="checkbox"/> None | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| Social skills: | <input type="checkbox"/> None | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| Emotions: | <input type="checkbox"/> None | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |

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2018/08 V4.2



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Have you had any concerns about your child's:	Yes	No	Comments (optional)
First year of development?	<input type="checkbox"/>	<input type="checkbox"/>	
Early motor development?	<input type="checkbox"/>	<input type="checkbox"/>	
Early language development?	<input type="checkbox"/>	<input type="checkbox"/>	
Early social development?	<input type="checkbox"/>	<input type="checkbox"/>	
Early learning?	<input type="checkbox"/>	<input type="checkbox"/>	

Please add any other relevant medical information about your child:

.....

.....

.....

Do you have **any concerns** about your child in the following areas?

Area of development	No concerns	Somewhat concerned	Very concerned	Unsure
Understanding what is said (language comprehension) Comments:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Expressing themselves with language (language expression) Comments:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reading and spelling (literacy skills) Comments:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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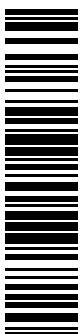
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Area of development	No concerns	Somewhat concerned	Very concerned	Unsure
Ability to use their hands for fine motor tasks (such as buttons, drawing, cutting, using cutlery) Comments:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gross motor tasks (such as running, jumping, balancing) Comments:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attention / distractibility / impulse control Comments:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Organising themselves Comments:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behaviour at home Comments:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social interaction with friends Comments:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotional well-being/self esteem Comments:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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Support Services

Has this child ever been involved with any of the following services? *(please tick)*

	Never	In the past	Currently	Not known
Paediatrician	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatrist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychologist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Counselling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child and Youth Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speech Pathology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physiotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Guidance Officer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Audiology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parenting/Behavioural programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Medical Specialist (e.g. ENT, Allergist)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you ticked *In the Past* or *Currently* for any of these, please describe below - (who, when, what and for how long). Please supply copies of any reports.

.....

.....

.....

Is there anything else you would like us to know about your child and/or family?

.....

.....

.....

Thank you for completing this questionnaire.

If your child is being reviewed by a GP, please take this information, along with the School or Kindy questionnaire, with you to the appointment.

If this information has been requested by the Sunshine Coast Hospital and Health Service, please return it to the appropriate service below:

Child Development Service
Caloundra Health Service
West Terrace
Caloundra
QLD 4551

Ph: 5436 8910
Fax: 5436 8584

Email: Child-Development-Service@health.qld.gov.au

Paediatric Outpatient Department
Gympie Hospital
Locked Bag 15
Gympie
QLD 4570

Phone: 5489 8536
Fax: 5489 8717

Email: GY-admin-SOPS@health.qld.gov.au

Children's and Adolescent's Clinic
Sunshine Coast University Hospital
6 Doherty Street
Birtinya
QLD 4575

Phone: 5202 3415
Fax: 5202 2688

Email: SC-Paediatric-Outpatients@health.qld.gov.au

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