DYNAMICS PSYCHOLOGICAL PRACTICE
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ASSESSEMENTS.
RECOMMENDATIONS.
SOLUTIONS.

Child Questionnaire

DYNAMICS PSYCHOLOGICAL PRACTICE

Child's Name: (PLEASE UNDERLINE SURNAME) Gender: F / M

Date Visited: DD / MM / YYYY Date of Birth: DD / MM / YYYY Age:

School: Grade:

Language(s) used at home: (IF MORE THAN ONE, PLEASE CIRCLE PRIMARY LANGUAGE)

Form completed by: (NAME, RELATION TO CHILD)

How did you hear about us?

☐ Friend Recommended ☐ School ☐ Website ☐ Doctor ☐ Other:

1. GENERAL INFORMATION

	FATHER	MOTHER
Name:		
Profession:		
Phone: (HOME)		
Phone: (WORK/MOBILE)		
Email Address:		
Home Address:		

Please indicate primary contact person with an asterix (*) or list alternate person here:

Name: Phone:

Other people living at home, apart from parent(s) and child:

NAME	AGE	RELATIONSHIP TO CHILD

MAIN CAREGIVER(S):

☐ PARENT(S)
☐ GRANDPARENTS
☐ AUNT / UNCLE
☐ MAID / HELPER

BIRTH DETAILS

Pregnancy length: (WEEKS) Weight at birth:

Birth procedure: (NORMAL, BREECH, CAESAREAN)

During pregancy were there complications / problems? ☐ Yes ☐ No

During birth and immediately following, did complications occur for child or mother? ☐ Yes ☐ No

If yes, please describe: (e.g. DIABETES, JAUNDICE, BREATHING PROBLEM, NEED OF INCUBATION, SWALLOWING DIFFICULTIES)

DEVELOPMENTAL MILESTONES

If known, at what age did the following occur:

Crawl _____
Walk (unassisted) _____
First sounds _____
First words _____
Use 2-word sentence _____

Day time bladder trained _____
Night time bladder trained _____
Can you child: Tie shoelaces? ☐ Yes ☐ No
Catch a ball? ☐ Yes ☐ No
Use scissors? ☐ Yes ☐ No

Has your child been involved in a major accident/undergone surgery? (INJURIES REQUIRING HOSPITALIZATION)

☐ Yes ☐ No Details:

Has your child been on or is now taking prescription medication?

☐ Yes ☐ No Details:

ENGAGEMENT WITH HEALTH ALLIED PROFESSIONALS

Please indicate (tick) past or present involvement with the following health professions:

Pediatrician: Name of Clinic:

Name of Doctor: Contact:

	PAST	PRESENT	KEY FOCUS & LENGTH OF INVOLVEMENT
Occupational Therapist	☐	☐	
Speech Therapist	☐	☐	
Neurologist	☐	☐	
Psychologist	☐	☐	

Has your child been examined on the following: If yes, when and results:

Hearing test ☐
Eye examination (any glasses) ☐
Allergy test ☐

3. MEDICAL HISTORY

Has or does..	your child		family members		If yes, list who:
HAVE:	NO	YES	NO	YES	
Asthma	☐	☐	☐	☐	
Hayfever / Allergies	☐	☐	☐	☐	
Epilepsy / Convultions / Fits	☐	☐	☐	☐	
Head Injury	☐	☐	☐	☐	
Speech or Language Difficulties	☐	☐	☐	☐	
Learning Difficulties	☐	☐	☐	☐	
Development Difficulties such as Dyspraxia, ADHD, Autism Spectrum Disorders	☐	☐	☐	☐	

4. EDUCATION HISTORY - FOR CHILD 3 YEARS+

Did or does your child attend Kindergarten? ☐ Yes ☐ No How many years:

Is your child attending or have attended Learning Support Program (LSP) in school? ☐ Yes ☐ No

If yes, length of time: Area in need of assistance:

Has the teacher raised any concerns?

☐ Yes ☐ No Details:

Is your child attending extra classes outside school? (e.g. TUITION)

☐ Yes ☐ No If yes, what is the focus and how often?

Has your child missed school for an extended period of time?

☐ Yes ☐ No If yes, length of time?

How does your child get along with teachers? ☐ Very well ☐ OK ☐ Unwell

Comments:

How does your child get along with classmates? ☐ Very well ☐ OK ☐ Unwell

Comments:

5. EXPERIENCES

Have your child witnessed any traumatic events? And when? (e.g. CAR COLLISION, ROBBERY, DEATH OF FAMILY MEMBER)

☐ Yes ☐ No Comments:

Have your child experienced any major stresses? And when?

(e.g. DIVORCE OF PARENTS, FAMILY ILLNESS, INTERNATIONAL RELOCATION, BULLYING, DEATH OF A CLOSE FRIEND / FAMILY MEMBER)

☐ Yes ☐ No Details:

6. PARENTAL OBSERVATIONS

1. Please indicate your current concerns: Since when?

(e.g. BEHAVIOURAL PROBLEMS, ANXIETY, MOOD, SELF-ESTEEM, MOTIVATION LEARNING)

2. How else have you tried to address concerns?

3. Which aspect(s) of daily living are being affected?

☐ Sleep ☐ Family relationships ☐ Learning ☐ Peer interactions ☐ Home routines ☐ Play / Activities

Using this line below, please indicate (mark) at what level your concern for your child is currently at:

MINIMAL CONCERN	**CONCERNED**	**WORRIED**	**VERY WORRIED**
MORE INQUISITIVE ABOUT CHILD'S BEHAVIOUR	NOTICING SOME CHANGES IN BEHAVIOUR	MANY UNEXPLAINED CHANGES IN BEHAVIOUR	NOT SURE HOW TO COPE

4. What do you hope to learn from engaging our services?

5. What strengths does your child have?

Does the mood change a lot depending on context?

(e.g. HOME, SCHOOL, TIME OF DAY, DAY OF WEEK)

☐ Yes ☐ No