

|  |
| --- |
| **Please return this form once completed to the person making the referral to Community Paediatrics to be included with the referral form** |

**PARENT QUESTIONNAIRE**

Please fill in as much of this form as you can. Not all areas will be relevant. The more information you give us, the better we can do our assessment. Every reference to ‘child’ is taken to mean ‘child or young person’.

We need to know about your own concerns as well as the concerns of other professionals, which may be different.

This information will enable the team to decide on the next step.

Thank you for your time.

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| --- | --- | --- | --- | --- | --- |
| **Child’s Name**  |  | **Date of Birth** |  | **Age** |  |
|  |  |  |  |  |  |  |
| **Gender** | **Male** |  | **Female** |  | **Prefer to self-describe as (please specify):****(non-binary, gender-fluid, agender)** |  |
|  |  |  |  |  |  |  |
| **Is your child’s gender identity the same as the sex they were assigned at birth?** | **Yes** |  | **No** |  | **Prefer not to say** |  |
|  |  |  |  |  |  |  |
| **Address**  |  |
|  |  |  |  |  |  |  |
| **Postcode**  |  | **Telephone Number**  |  |
|  |
| **Email**  |  |
|  |  |
| **GP Practice**  |  | **School**  |  |
|  |  |  |  |  |
| **Date Form Completed**  |  | **Completed By** |  |

|  |
| --- |
| **Ethnicity** |
| **White**  | **Asian or Asian British**  | **Black or Black British** | **Mixed** | **Other Ethnic Group** |
| British  |  | Indian  |  | Caribbean  |  | White and Black Caribbean  |  | Chinese  |  |
| Irish  |  | Pakistani  |  | African  |  | White and Black African  |  | Any other Ethnic group  |  |
| Any other White background  |  | Bangladeshi  |  | Any other Black background  |  | White and Asian  |  | Prefer not to say |  |
| Any other Asian background |  |  |  | Any other mixed background  |  |  |  |

|  |
| --- |
| **Religion or other belief system** |
| Baha’i  |  | Jain  |  | Hindu |  | Pagan |  | Prefer not to say |  |
| Buddhist  |  | Jewish  |  | Sikh |  | None  |  | Other: |
| Christian  |  | Muslim |  | Zoroastrian |  | Not Known |  |

|  |
| --- |
| **Communication**  |
| Main Language:  |
| Able to communicate in Spoken English  | Yes  | No  |
| Able to Understand Written English  | Yes  | No  |
| Translator Needed  | Yes  | No  |

|  |
| --- |
| **Reason for Referral**  |
|  |
| **Parent/Carer/Child Concerns and what are your hopes from making this referral (write down what worries you, what support you are hoping for & questions you want to ask in clinic)**  |
|  |
| **Nurseries and School Attended (with dates)**  |
|  |

|  |
| --- |
| **Professionals involved with the child (please state details if known)** |
| **Service/****Professional** | **Current or past and estimated dates** | **Reason for involvement** | **What support was received** |
| Speech and Language Therapy:  | Current/PastStart date………………End date:……………… |   |  |
| Paediatrician:  |  Current/PastStart date………………End date:……………… |   |  |
| Occupational Therapy:  |  Current/PastStart date………………End date:……………… |   |  |
| Child and Adolescent Mental Health Service (CAMHS):  | Current/PastStart date………………End date:……………… |   |  |
| Healthy Minds: | Current/PastStart date………………End date:……………… |  |  |
| Physiotherapy:  | Current/PastStart date………………End date:……………… |   |  |
| Educational Psychology:  | Current/PastStart date………………End date:……………… |   |  |
| Children and young people’s nurses:  | Current/PastStart date………………End date:……………… |  |  |
| Social Worker:  | Current/PastStart date………………End date:……………… | Open to Child in need: Yes/NoReason:Open to Child Protection: Yes/NoReason: |  |
| Early Years inclusion team (for example Portage, SENCO):  | Current/PastStart date………………End date:……………… |   |  |
| Early Help Worker | Current/PastStart date………………End date:……………… |  |  |
| Working Together Team | Current/PastStart date………………End date:……………… |  |  |
|  Behaviour Outreach Support Service (BOSS) | Current/PastStart date………………End date:……………… |  |  |
| **Others – please list below:** |
|   | Current/PastStart date………………End date:……………… |   |  |
|   | Current/PastStart date………………End date:……………… |   |  |

**Past Medical History
Pregnancy and Early History**

|  |
| --- |
| **Any problems in pregnancy**  |
|  |
| **Any illnesses**  |  | **Bleeding**  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Tablets / medication** |  | **Cigarettes / Alcohol** |  |

|  |
| --- |
| **Any problems on any of the scans during pregnancy** |
|  |

**Labour**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Spontaneous Onset**  |  | **Induced**  |  | **Full Term**  |  |

|  |  |
| --- | --- |
| **If premature, by how many weeks** |  |

**Delivery**

|  |  |  |  |
| --- | --- | --- | --- |
| **Place of Birth** |  | **Birth Weight**  |  |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Normal**  |  | **Breech**  |  | **Forceps** |  | **Ventouse** |  | **Caesarean** |  |

|  |
| --- |
| **Was there any sign that the baby was distressed before birth**  |
|  |

|  |
| --- |
| **Did he/she need help with breathing** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Yes**  |  | **No** |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Did he/she need Special Care** |  | **Yes**  |  | **No** |  |

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| --- |
| **Any problems in the new-born period** |
|  |

|  |  |
| --- | --- |
| **How old was the baby when you took him/her home** |  |

**Early Feeding and Weaning**

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| --- |
| **Any feeding problems early on** |
|  |

|  |  |
| --- | --- |
| **If breast fed, until what age** |  |

|  |  |
| --- | --- |
| **Solids introduced at what age**  |  |

**Subsequent Medical History**

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| --- |
| **Please write down any diagnoses or conditions your chid has and age they were diagnosed** |
|  |

 **Hospital Visits**

|  |
| --- |
| **Please write down as much as you remember, including which hospital, which department, when and what for**  |
|  |

 **Other illnesses or accidents**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Measles** |  | **Mumps** |  | **Chicken Pox** |  | **German Measles** |  | **TB**  |  |

|  |  |
| --- | --- |
| **Other**  |  |

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| --- |
| **Any Complications**  |
|  |

**Immunisations**

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| --- |
| **Please write down any jabs that you know your child has NOT had, which they would usually have had by now, including the reason for them not having it**  |
|  |

**General Health – Does your child have any of the following:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **A regular Cough**  |  | **Asthma**  |  | **Eczema or other skin problem**  |  | **Bowel Problem** |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Difficulties passing water**  |  | **Urine Infections** |  | **Fits, faints or funny turns**  |  | **Headaches**  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Heart problems**  |  | **Any other medical, dental or mental health problems**  |  |
|  |
| **Please give further details** |
|  |

|  |  |
| --- | --- |
| **When did he/she last see the dentist**  |  |

|  |
| --- |
| **Medication including doses and times given**  |
|  |
| **Allergies to medication, or anything else, including a description of any reactions**  |
|  |

 **Family History**

|  |  |
| --- | --- |
| **Name of birth mother**  |  |

|  |  |
| --- | --- |
| **Date of Birth**  |  **/ /**  |

|  |  |
| --- | --- |
| **Health**  |  |

|  |  |
| --- | --- |
| **Occupation**  |  |

|  |  |
| --- | --- |
| **Name of birth father** |  |

|  |  |
| --- | --- |
| **Date of Birth**  |  **/ /**  |

|  |  |
| --- | --- |
| **Health**  |  |

|  |  |
| --- | --- |
| **Occupation**  |  |

|  |
| --- |
| **Are birth parents related, e.g. Cousins?**  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Yes**  |  | **No** |  |

|  |
| --- |
| **Are both parents living at home** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Yes**  |  | **No** |  |

|  |  |
| --- | --- |
| **If no, how often is contact**  |  |

|  |
| --- |
| **Contact details of parent if not the same as address on front page**  |
|  |

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| --- |
| **Is the child adopted or a looked after child?**  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Yes**  |  | **No** |  |

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| --- |
| **If yes, please provide details including whether the child is adopted, fostered or under special guardianship etc, how long for and reasons for not living with birth parents (if known)**  |
|  |

|  |
| --- |
| **Details of everyone else living at home**  |
| **Name**  | **Date of Birth**  | **Health**  |
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| --- |
| **Any brothers/sisters or half-siblings not living at home** |
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| --- |
| **Have you or anyone in the close family had any miscarriages, stillbirths, or had a young child who died** |
|  |

|  |
| --- |
| **Please write if anyone in the family (parents, siblings, grandparents, cousins etc) have had health problems in any of the following areas** |
| **Hearing**  |  |
| **Vision**  |  |
| **Speech**  |  |
| **Learning**  |  |
| **Epilepsy, fits or funny turns**  |  |
| **Muscle problems**  |  |
| **Physical disability**  |  |
| **Mental health problems**  |  |

|  |
| --- |
| **Other health problems (please say what)**  |
|  |

|  |
| --- |
| **Did anyone in the family go to special school or need extra help at school**  |
|  |

**Housing**

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| --- |
| **Please write down any issues as we can sometimes help**  |
|  |

|  |
| --- |
| **Does anyone smoke at home** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Yes**  |  | **No** |  |

|  |
| --- |
| **Are there any pets**  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Yes**  |  | **No** |  |

**Support and Information**

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| --- |
| **Where do you get your support from (e.g. grandparents, friends etc)**  |
|  |

|  |
| --- |
| **Do you get any special benefits e.g. DLA** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Yes**  |  | **No** |  |

|  |
| --- |
| **Do you use respite care or short breaks**  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Yes**  |  | **No** |  |

|  |
| --- |
| **Do you get the support you need to care for your child (if not please say what support you need)**  |
|  |

|  |
| --- |
| **Do you have enough information about your child and services available (if not say what you want)**  |
|  |

**Developmental history and current functioning**

|  |
| --- |
| **Please describe how your child plays, what he/she enjoys and what she/he is like as a person** |
|  |

**Movements and posture**

|  |  |
| --- | --- |
| **How does your child move around**  |  |

|  |
| --- |
| **Please list any equipment required to assist with movements or posture**  |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| **At what age did he/she sit without support** |  | **Walk alone**  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Climb stairs**  | **Yes**  |  | **No**  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Run**  | **Yes**  |  | **No**  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Kick a ball**  | **Yes**  |  | **No**  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Pedal a bike**  | **Yes**  |  | **No**  |  |

**Can he/she:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Jump with feet together**  | **Yes**  |  | **No**  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Get up easily from sitting on the floor, without using their hands**  | **Yes**  |  | **No**  |  |

|  |
| --- |
| **What are her/his best skills in the area of movement**  |
|  |

|  |
| --- |
| **Please write down any worries about movements, posture, balance or coordination**  |
|  |

**Personal care and hand function**

|  |
| --- |
| **Which hand does he/she use the most** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Right**  |  | **Left** |  |

|  |  |
| --- | --- |
| **At what age did they reach/grab for toys** |  |

|  |
| --- |
| **What is her/his best skills in this area**  |
|  |

|  |
| --- |
| **please write down any difficulties with personal care skills (feeding, dressing, toileting, washing etc)**  |
|  |

**Feeding**

|  |
| --- |
| **Can she/he manage a range of textures without a problem**  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Yes**  |  | **No** |  |

|  |
| --- |
| **Any retching, vomiting or acid brash**  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Yes**  |  | **No** |  |

|  |
| --- |
| **What is her/his best skills in this area**  |
|  |

|  |
| --- |
| **Please write down any difficulties with feeding, chewing or swallowing, including details of special diet etc**  |
|  |

**Continence**

|  |
| --- |
| **What is her/his best skills in this area**  |
|  |

|  |
| --- |
| **Please write down any concerns**  |
|  |

**Hearing**

|  |
| --- |
| **What is her/his best skills in this area**  |
|  |

|  |
| --- |
| **Please write down any concerns and any tests your child has had**  |
|  |

**Vision**

|  |
| --- |
| **What is her/his best skills in this area**  |
|  |

|  |
| --- |
| **Please write down any concerns and any tests your child has had**  |
|  |

**Speech, Language and Social Communication**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Did / do they enjoy peekaboo**  | **Yes** |  | **No** |  |

|  |  |
| --- | --- |
| **Age of first smile**  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Did they go through a phase of babbling**  | **Yes** |  | **No** |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **As a baby were they** | **Quiet**  |  | **Noisy**  |  | **Vocal**  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Did they smile at you to greet or get your attention**  | **Yes** |  | **No** |  |

|  |
| --- |
| **How does your child communicate (speech, signing, gestures, picture exchange)** |
|  |

|  |
| --- |
| **Is she/he able to indicate a clear yes/no response and how is this done** |
|  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **If speech is the main means of communication, is this clear for a stranger to understand** | **Yes** |  | **No** |  |

|  |
| --- |
| **Is there anything unusual about the quality or tone of speech**  |
|  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Point at things to ask for them**  | **Yes**  |  | **No**  |  |

**Does he/she:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **To share interest with you (‘oh look there’s a..’)**  | **Yes**  |  | **No**  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Does he/she bring things to show you to share interest with you (e.g. toys, books etc)**  | **Yes**  |  | **No**  |  |

|  |
| --- |
| **Please describe any pretend/creative imaginative play that your child does now**  |
|  |

|  |
| --- |
| **Did she/he play with imagination as a small child (e.g. pretend to feed teddy, pretend to make a drink etc)**  |
|  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Does he/she show interest in what you are doing and try to copy what you do**  | **Yes**  |  | **No**  |  |

|  |
| --- |
| **Please give examples:**  |
|  |

|  |
| --- |
| **Please describe how your child plays with other children and the sort of things they do together**  |
|  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Do they enjoy cuddles** | **Yes**  |  | **No**  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Do they have a special friend**  | **Yes**  |  | **No**  |  |

|  |
| --- |
| **When would he/she come for a cuddle**  |
|  |

|  |
| --- |
| **How does she/he react if you are hurt or upset**  |
|  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Would they show concern or offer a cuddle** | **Yes**  |  | **No**  |  |

|  |
| --- |
| **How does she/he generally respond to others’ emotions**  |
|  |
|  |
| **Please give examples of her/his best skills in understanding what you say**  |
|  |

|  |
| --- |
| **Please give examples of her/his best skills in speech and communication**  |
|  |

|  |
| --- |
| **Please write down any concerns with speech, language or social communication**  |
|  |

**Learning**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Is your child learning new things all the time**  | **Yes**  |  | **No**  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Do they get extra help at school**  | **Yes**  |  | **No**  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Are there any things that they used to be able to do, but can’t anymore e.g. do you think they have lost any developmental skills**  | **Yes**  |  | **No**  |  |

|  |
| --- |
| **Please specify what**  |
|  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Do they have an Individual Education Plan**  | **Yes**  |  | **No**  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Do they have an Educational Healthcare Plan** | **Yes** |  | **No**  |  |

|  |
| --- |
| **What are her/his best skills overall with learning (e.g. remembering routes to places or things that happened, counting, building, puzzles, computers, maths, reading etc)**  |
|  |

|  |
| --- |
| **Please write down any concerns about your child’s learning or developmental progress**  |
|  |

**Behaviour**

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| --- |
| **Please give examples of best behaviour**  |
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|  |
| --- |
| **Please describe any unusual habits or mannerisms**  |
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| --- |
| **Does she/he show any repetitive or unusual aspect to play (e.g. lining up toys, playing with wheels rather than the cars, sniffing or feeling things in an unusual way)**  |
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|  |
| --- |
| **How does he/she react to any changes in routine**  |
|  |

|  |
| --- |
| **Does she/he have any rituals of behaviour at any time (e.g. having to do things in a particular order, or sit in a particular place etc)**  |
|  |

|  |
| --- |
|  **Does he/she show any unusual sensitivities (e.g. household noises, particular objects or situations)**  |
|  |

|  |
| --- |
| **Please write down any concerns about behaviour**  |
|  |

**Mental Health and Emotional Wellbeing**

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| --- |
| **Do you have any concerns about your child’s mental health or emotional wellbeing. For example, social anxiety, separation anxiety or low mood.** |
|  |

|  |
| --- |
| **Has he or she experienced any upsetting family circumstances or what might be considered as traumatic experiences? This could include but is not limited to: physical abuse, emotional abuse, sexual abuse, neglect, bullying, bereavement or loss, witnessed domestic violence, witness family alcohol or substance misuse, parental relationship breakdown, witnessed or cared for a parent with significant mental or physical health difficulties, been in an accident. Please provide a brief description.**  |
|  |

**Sleep**

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| --- |
| **Please describe your child’s sleep pattern and any concerns**  |
|  |

|  |
| --- |
| **Please write here anything else you that it is important for us to know about your child, your family or your circumstances (continues over page)**  |
|  |

**Thank you very much for getting this far**

**All of this information will help us to help your child**

|  |
| --- |
| **Please return this form once completed to the person making the referral to Community Paediatrics to be included with the referral form** |