MEDSANA
MEDICAL CLINIC

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Parent Questionnaire

Child's Name: _____ Date Of Birth: _____

Parent/Guardian One	Name:	Occupation:
Parent/Guardian Two	Name:	Occupation:

Please nominate one parent to receive communication such as text messages, letters etc.

Name of parent for communication: _____

Name of Preschool / Day care / Kindergarten: _____

How long has your child attended? _____

What are your child's strengths, interests, makes them happy?

What are your concerns?

Health:	
Do you have any concerns of your child's health currently?	
Any accidents/injuries/ serious illness in past?	
Any allergies?	
Is your child fully immunised?	
Are there other medical concerns?	
Hearing was checked ? Was it normal?	
Vision was checked ? Was it normal?	
Pregnancy and Birth:	
Any concerns about pregnancy?	
Any concerns about birth?	
Did he/she require resuscitation at birth?	
What was your child's birth weight?	
Was your child born close to due date or if early by how many weeks?	
Development:	
Did you have concerns for any of the following?	
First year: Hard to settle, or poor weight gain?	
Motor: sitting, crawling, walking, running, kicking, balance?	
Speech (talking, understanding)	
Learning (colours, shapes, drawing, counting)	

Social (eye contact, play, friends)	
Family:	
Does any family have development, learning, behavioural, emotional, psychiatric problems or problems similar to your child?	
Have you consulted others currently or in the past?	**Name**
Paediatrician	
Psychiatrist	
Occupational therapist	
Physiotherapist	
Speech therapist	
Psychologist	
Social worker/ counsellor	
School guidance officer	
Support teacher	
Home tutor	
Other	