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**PARENT QUESTIONNAIRE**

|  |  |  |
| --- | --- | --- |
| Child’s name: |  | Date of birth: |
|  |  |  |

Mother’s name:

|  |
| --- |
|  |

Address:

|  |
| --- |
|  |

Contact Numbers (including home, work and mobile):

|  |
| --- |
|  |

Email:

|  |
| --- |
|  |

Father’s name:

|  |
| --- |
|  |

Address (if different from above):

|  |
| --- |
|  |

Contact Numbers (including home, work and mobile):

|  |
| --- |
|  |

Email:

|  |
| --- |
|  |

Caregiver’s name (if different from above):

|  |
| --- |
|  |

Address:

|  |
| --- |
|  |

Contact Numbers (including home, work and mobile):

|  |
| --- |
|  |

Email:

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| --- |
|  |

|  |  |  |
| --- | --- | --- |
| Sibling/s name/s: |  | Sibling/s age/s: |
|  |  |  |

|  |  |  |
| --- | --- | --- |
| School: |  | Teacher’s name: |
|  |  |  |

Does your child receive any additional support from any of these services (tick if appropriate):

|  |  |
| --- | --- |
| Service: | Provider/s: |
|  Teacher Aide |  |
|  Reading Recovery |  |
|  Resource Teacher for Learning & Behaviour (RTLB) |  |
|  Special Education |  |
|  Speech Therapy |  |
|  Physiotherapy |  |
|  Occupational Therapy |  |
|  CAMHS |  |

BIRTH HISTORY

Were there any problems during the pregnancy?

|  |
| --- |
|  |

Was your child born on time or prematurely?

|  |
| --- |
|  |

What was your child’s birth weight?

|  |
| --- |
|  |

Were there any problems immediately after birth?

|  |
| --- |
|  |

DEVELOPMENTAL HISTORY

At approximately what age did you child first…

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Smile: |  |  | Walk well: |  |
| Roll over: |  |  | Feed self finger foods: |  |
| Sit alone: |  |  | Speak first real words: |  |
| Crawl |  |  | Speak first sentences: |  |
| Stand alone: |  |  | Become toilet trained: |  |

MEDICAL HISTORY

|  |  |  |
| --- | --- | --- |
| Has vision been tested? |  | Result: |
| Yes/ No |  |  |

|  |  |  |
| --- | --- | --- |
| Has hearing been checked? |  | Result: |
| Yes/ No |  |  |

Please list any serious illnesses, injuries, hospitalisations and/ or operations:

|  |
| --- |
|  |

Has your child ever had any of the following:

|  |  |
| --- | --- |
|  Eye/ vision problems |  Epilepsy |
|  Ear/ hearing problems |  Meningitis |
|  Speech or language difficulties |  Head injury |
|  Febrile seizures |  Feeding difficulties |

Current medications:

|  |
| --- |
|  |

EDUCATION

Preschools Attended:

|  |  |
| --- | --- |
| Name of Preschool/s | Dates Attended |
|  |  |

Schools Attended:

|  |  |
| --- | --- |
| Name of School/s | Dates Attended |
|  |  |

FAMILY HISTORY

|  |  |
| --- | --- |
| Is there a history in the family of any of the following: | Relationship to child (eg, sibling, cousin, parent etc) |
|  Epilepsy |  |
|  Attention Deficit Hyperactivity Disorder |  |
|  Autism/ Aspergers Syndrome |  |
|  Learning difficulties  |  |
|  Speech and language difficulties  |  |
|  Any other health concerns |  |

GENERAL

|  |  |  |
| --- | --- | --- |
| What are your child’s likes/ interests? |  | Dislikes? |
|  |  |  |

|  |  |  |
| --- | --- | --- |
| What are your child’s strengths? |  | Weaknesses? |
|  |  |  |

Is your child overly sensitive to certain noises, textures, smells, etc?

|  |
| --- |
|  |

Does your child have difficulties with movement skills and coordination (eg, walking, running, balance, ball skills, riding a bike?

|  |
| --- |
|  |

Does your child have difficulty with hand skills (eg, pencil/ writing skills, using a knife and fork or dressing themselves)?

|  |
| --- |
|  |

Does your child have difficulty with communication skills (eg, understanding instructions, pronouncing words, hearing difficulties etc)?

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| --- |
|  |

Is there any other information that you feel may be of relevance?

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|  |

Is there any information you would prefer not to discuss in front of your child?

|  |
| --- |
|  |

What information/ assistance would you like to obtain from this appointment?

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| --- |
|  |

Please add any further information you would like to share:

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| --- |
|  |

|  |  |  |
| --- | --- | --- |
| Signature: |  | Date: |
|  |  |  |

*Thank you for taking the time to complete this form.*