Learning & Development *for Children*

PARENT QUESTIONNAIRE

CHILD'S NAME	
DATE OF BIRTH	

Mother's Name	
Father's Name	
Sibling/s Names & Ages	
Who referred you to *Learning & Development for Children?*	
Position of referring person (eg., Paediatrician)	

State the main reasons and issues that prompted you to seek professional help.

Describe what your child is having difficulties with and in what situations.

Circle the rating which best describes your level of concern for your child.
Please include comments and information you consider relevant.

MOTHER	Not at all	A little	Moderately	Quite a lot	Extremely
FATHER	Not at all	A little	Moderately	Quite a lot	Extremely

Describe what you would like help with.

YOUR CHILD'S QUALITIES

Describe your child's personality. Tell us his / her special qualities.

List what your child does well. Include subjects and activities he/she does well in and takes pride in.

List your child's interests.

SUPPORT FOR LEARNING

Outline support (if any) that your child has received or is receiving both within and outside of school (e.g., tutor for reading and maths). Please indicate approximate dates.

Please rate or describe the following (add comments if you experienced concerns):

Pregnancy & Birth			
Your pregnancy	No concerns	I/we had concerns	Comment:
Your child's birth & postnatal period	No concerns	I/we had concerns	Comment:
Your child's birth weight	Birth weight:		
Length of Pregnancy	Full term	Premature	No. of weeks premature or other comment:
Early Development			
Your child's first year (e.g., settling; feeding; weight gain)	No issues	Some issues	Comment:
Motor development (e.g., walking; running; jumping)	No concerns	I/we had concerns	Comment:
Language development (e.g., using words; understanding others; talking)	No concerns	I/we had concerns	Comment:
Social Development (e.g., smiling & interacting with others; playing with other children; making friends)	No concerns	I/we had concerns	Comment:
Learning skills (e.g., understanding concepts of colour or number; drawing; alphabet)	No concerns	I/we had concerns	Comment:
Family History			
Family members (mother, father, grandparents, siblings, aunts, uncles) with similar learning problems to your child	No	Yes	List person/s and describe:
Family members (mother, father, grandparents, siblings, aunts, uncles) with different developmental, physical, learning, social, or emotional problems to your child	No	Yes	List person/s and describe:

Hearing	Checked and OK	Some issues	Describe:
Vision	Checked and OK	Some issues	Describe:
Previous accidents, injuries, or serious illnesses	No	Yes	List and describe:
Current health	No concerns	Some issues	Describe:

PROFESSIONALS SEEN

Professional Services		**Currently Attending** (please tick)	**Attended in Past** (please tick)	**Approximate Dates of Service & Reason**
Paediatrician	Name:			
Child Psychiatrist	Name:			
Psychologist	Name:			
Speech Pathologist	Name:			
Physiotherapist	Name:			
Occupational Therapist	Name:			
Social Worker or Counsellor	Name:			
Other	Name:			
Educational Services		**Currently Attending** (please tick)	**Attended in Past** (please tick)	**Approximate Dates of Service & Reason**
School Guidance Officer				
Learning Support Teacher				
Tutor				
Other				

PLEASE ATTACH COPIES OF MEDICAL, THERAPY, OR EDUCATIONAL REPORTS PERTINENT TO THE ABOVE.

Describe your expectations for this referral.

Please return the completed questionnaire to *Learning and Development for Children* at your earliest convenience.

THANK YOU FOR YOUR TIME IN COMPLETING THIS QUESTIONNAIRE.

Questionnaire completed by *(please print)*

Date

CONTACT DETAILS

☐ **Dr Deberea Sherlock**

Practice Address: Ashgrove Serviced Offices
Level 1 "Highpoint"
240 Waterworks Road
Ashgrove QLD 4060

Appointments Ph: 3510 2145

Fax: 3366 9344

Email: info@masterinstitute.com.au

Website: www.ladfc.com.au