Dr Garth Smith
Paediatrics Ltd
PO Box 3826
Richmond
Nelson 7050

PARENT INFORMATION REQUEST

Date:

Dear Parents

In order for us to cover all of the information in your child's appointment, please print off and complete this form to the best of your knowledge and bring it with you to the clinic appointment. Items of a personal or private nature will be kept confidential. Please feel free to add any comments to help clarify your answers.

Thank you

Dr Garth Smith
Paediatrician

PARENT QUESTIONNAIRE

Child's name:		DOB:
Mother's name:		
Address		
Phone No: Home:	Work:	Mobile:
Email:		
Father's name:		
Address (if different from above)		
Phone No: Home:	Work:	Mobile:
Email:		
Caregiver's name (if different from above)		
Address:		
Phone No: Home:	Work:	Mobile:
Brothers/Sisters: Name		Age:
School:		Teacher:

Date this form was filled in ____________________

This form was filled in by ___________________________ (your name)

who is the ___________________ (relationship to child) of __________________________ (child's name)

Does your child receive any additional support from any of these services?	(tick if appropriate)
Service	**Therapist's name**
☐ Teacher Aide	
☐ Reading Recovery	
☐ Resource Teacher for Learning & Behaviour (RTLB	
☐ Special Education	
☐ Speech Therapy	
☐ Physiotherapy	
☐ Occupational Therapy	
☐ CAMHS	

Are you happy for a member of our team to contact the School or any of the above service in order to provide further information regarding your child?	Yes / No
Does your child receive Child Disability Allowance?	Yes / No
Does your child receive ORRS funding?	Yes / No
Does your child receive funding from ACC?	Yes / No

Birth History

Any problems during the pregnancy?
Was your child born on time or prematurely?
Birth Weight?
Any problems immediately after birth?

Developmental History

At approximately what age did your 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 checked?	Yes / No	Result:
Has hearing been checked	Yes / No	Result:

List serious illnesses/injuries/hospitalisations/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:

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 (e.g. walking, running, balance, ball skills, riding a bike)

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

Does your child have difficulties with communication skills (e.g. understanding instructions, pronouncing words, hearing difficulties, etc.)

Is there any other information that you feel may be of relevance? (please use back of page for extra space)

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

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

Signature: Date:

Comments:

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Thank you for taking the time to fill in this checklist