

PARENT/CARER QUESTIONNAIRE For ALL AGES

<p>Thank you for taking the time to complete this questionnaire. This questionnaire forms part of the referral for Neurodevelopmental assessments. The information provided is an important part of the full assessment for the child and will hopefully assist in informing the evaluation of their needs.</p>	
Name of child:	Date of birth:
Form completed by (name):	Relationship to the child:
Date completed:	Telephone number:
Address the child lives at:	
Name of school/playgroup/nursery:	
<p>Which of the following professionals are currently / have been previously involved with your child? (GP, Community Paediatrician, Health Visitor, School Nurse, Speech and Language Therapist, Clinical Psychologist, Educational Psychologist, Early Years Teacher, Early Help, Social Care, ADHD Solutions, Inclusion Service?) Provide their details</p>	
Background information	
Language(s) spoken at home (please indicate the child's main language, the parent's preferred language and if an interpreter is needed):	
Who lives with the child?	
Who has Parental Responsibility?	
Please describe your child's interests and strengths	
Who else knows the child well and can provide information on the child's difficulties at home, school or in the community?	
<p>Is there any family history of the following? ASD, attention and concentration difficulties, ADHD, difficulties with reading, writing or spelling, dyslexia, mental health difficulties (worries, mood or paranoia), genetic conditions, speech and language difficulties, social interaction difficulties, physical and coordination difficulties:</p>	
Any major events that have been stressful for the family?	

Medical History

Were there any problems during the pregnancy or birth of the child?

Has the child ever been admitted to hospital or been under review by a Consultant? If yes, please provide further details below:

Does the child currently have / previously had any other medical conditions/problems?

Does the child take any liquid medicines, tablets, inhalers etc.? If yes, please give details below:

Current Concerns

What are you particularly concerned about at this point in time?

On a scale of 1 to 10 (1 being low and 10 being high), how concerned are you about your child's behaviour?

On a scale of 1 to 10 (1 being low and 10 being high), how well do you understand your child's behaviour?

Does your child's behaviour impact on home life, your relationships and / or your level of stress? If yes, please indicate whether is a lot of the time, most of the time or sometimes.

Are there any aspects of behaviour that are difficult to manage?

Has there been any previous support? Are there any strategies that are helpful?

Are there any concerns at school? What have the school shared with you?

What do you hope to gain from this referral?

Do you have concerns about any of the following areas:		
Development/Learning Please mention if the child has learning difficulties/has the child lost any skills or Abilities/were there delays in reaching developmental milestones?	No concerns <input type="checkbox"/>	Yes (please give details): Please describe any support received:
Play	No concerns <input type="checkbox"/>	Yes (please give details):
Communication	No concerns <input type="checkbox"/>	Yes (please give details):

Social Skills How are the child's relationships with other children?	No concerns <input type="checkbox"/>	Yes (please give details):
How are the child's relationships with other adults?	No concerns <input type="checkbox"/>	Yes (please give details):
Concentration	No concerns <input type="checkbox"/>	Yes (please give details):
Activity levels	No concerns <input type="checkbox"/>	Yes (please give details):
Wellbeing Does the child have any difficulties with anxiety, self-esteem, low mood?	No concerns <input type="checkbox"/>	Yes (please give details):

Sleep	No concerns <input type="checkbox"/>	Yes (please give details)
Eating	No concerns <input type="checkbox"/>	Yes (please give details)
Self-care skills	No concerns <input type="checkbox"/>	Yes (please give details):
Sensory needs	No concerns <input type="checkbox"/>	Yes (please give details):
Tics	No concerns <input type="checkbox"/>	Yes (please give details):
Obsessions / compulsions	No concerns <input type="checkbox"/>	Yes (please give details):
Repetitive or unusual behaviours	No concerns <input type="checkbox"/>	Yes (please give details):
Are there any risks to the child from themselves or others?	No concerns <input type="checkbox"/>	Yes (please give details):
If there is any further information you would like to provide?		