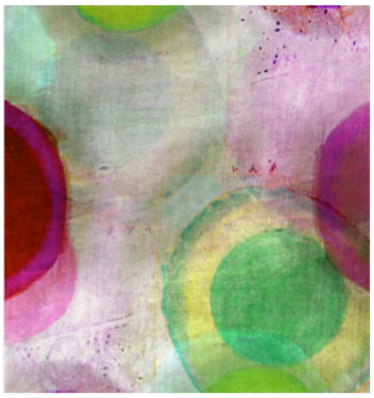

kidthink psychology

Initial Assessment Parent Questionnaire

Child's Name	
Date of Birth	
Mother's Name	
Father's Name	
Sibling/s Names and Ages	
Contact Phone Number (s)	
Address	
Email address	
Questionnaire completed by	
Date completed	
Who referred you to kidthink psychology?	
General Practitioner/Paediatrician Name Contact Details	

FAMILY INFORMATION

COMPOSITION OF FAMILY IN WHICH CHILD CURRENTLY RESIDES
(Primary Caregivers)

FATHER'S NAME: _____

DATE OF BIRTH: _____

RELATIONSHIP TO CHILD (please circle): Biological Adoptive Step Foster Other

MOTHER'S NAME: _____

DATE OF BIRTH: _____

RELATIONSHIP TO CHILD (please circle): Biological Adoptive Step Foster Other

BIOLOGICAL PARENT INFORMATION
(if not current caregiver or different from above):

FATHER'S/MOTHER'S NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____

PHONE #: _____

IF BOTH PRIMARY CAREGIVERS WORK, WHO CARES FOR THE CHILD?

ADDRESS: _____

PHONE#: _____

WHEN IS CHILD IN THIS CHILDCARE? _____

OTHER PERSONS LIVING IN THIS CHILD'S HOUSEHOLD:

NAME SEX AGE RELATIONSHIP TO CHILD

_____

_____

_____

_____

_____

_____

_____

_____

FAMILY STRESSORS (please note/explain if any of the following stressful events happened in the last 12 months):

ITEM	NO	YES	EVENT	EXPLANATION
1			Marital separations/divorce	
2			Death in the family	
3			Financial crisis	
4			Job change/difficulties	
5			School problems	
6			Legal problems	

7			Medical problems	
8			Household move	
9			Extended separation from parents	
10			Other stressful event	

Reason for referral

What are the main reasons that you sought professional help?

Please describe the areas of difficulty for your child.

Please describe your biggest concern for your child and what would you most like help with.

Your child

Please describe your child and their personality.

What are your child's strengths? Include subjects/activities that your child enjoys and is proud of.

What are your child's interests? What is motivating for your child?

Your Child's History

Diagnoses Please list any diagnoses for your child	
Pregnancy Please provide following details Were there complications during pregnancy? Was your child born full term? Were there complications during birth? Birth weight	
Developmental Areas Please describe areas of difficulty and strength for your child in the following areas:	
Communication skills (e.g. speech and comprehension)	
Thinking skills (i.e. ability to problem solve, attention span and concentration)	
Motor skills (e.g. running, jumping, writing, feeding)	

Self care skills (e.g. feeding, grooming, dressing)	
Social skills (e.g. ability to interact with others, start and maintain an appropriate interaction)	

Health Care History

Current Health Status	
Medical Practitioners (current and past) Include Paediatricians, General Practitioners and Specialists	
Hearing checked (Y/N) Provide details	
Vision checked (Y/N) Provide details	
Any past major illnesses or injuries (Y/N) Provide details	

Current and past medications	

Previous Support

Please describe any previous intervention or support that you have sought for your child. Please include type of support and professional involved and approximate dates. E.g. Speech Pathologists, Psychologists, Paediatrician, Psychiatrist, Occupational Therapist.

Please bring along copies of reports or letters from the above professionals to your initial consult.

Expectations

Please outline what you would like to get out of this referral.

Thankyou for your time in completing this questionnaire. It will provide the psychologist with useful information for your sessions. Please bring the completed copy to your first session or return via email to reneemuller@kidthink.com.au