

**SchoolKit Clinic Questionnaire**

* + - Please complete and return to your child’s teacher.
    - If you require assistance completing this form or have any questions, please contact the school.
    - Attach any other relevant reports (medical, therapy, or other relevant questionnaires provided by the school) to this questionnaire.

Child’s first name:

Child’s surname: Date of Birth:

School:

Address:

Name of person providing information:

Relationship to child:

Telephone number:

Email address:

Signature of parent/carer Date

**List of medical diagnoses**

Has your child been assessed as having developmental delay or intellectual disability?  
   
Details:

**Professionals / Agencies involved with child**

(e.g. GP, therapists, hospitals, specialists, others (past and current)):

### Name Agency/Profession How often Permission to contact/obtain reports from (Y/N)

I give permission for the school to invite the relevant clinicians/professionals involved in my child’s care   
to attend the appointment.

### 

Signature of parent/carer Date

**Educational history**

(Past schools if relevant)

Name Dates/duration attended

**Background to referral**

What are **your** concerns (if any) about your child?

Has the Learning Support Team been involved with your child? If yes, what were their recommendations?

What are your expectations from this clinic? How would you like us to help you?

**General health**

Has your child had any of the following problems? If so, please circle and describe:

Significant health problems/ illness / accident / medical diagnosis / syndrome:

Hospitalisations/ operations:

Bowel / urinary problems:

Fits or convulsions:

Dental problems:

Visual problems:

Hearing difficulties/ recurrent ear infections/ earaches:

Frequent colds /throat infections /other:

Sleep problems:

Diet/Nutrition problems:

**Medications:** Does your child take any regular medications?

Type Dose Frequency Reason/ Condition

**Immunisations:** Are your child’s immunisations up to date? Yes / No

**Allergies:** Does your child have any known allergies? Yes / No (if yes, please list):

My biggest difficulty with my child is:

My child is good at:

My child likes to play with:

My child does not like:

Life with my child right now feels:

**0**  1  2  3  4  **5**  6  7  8  9  **10**

**(Comfortable) (Up & Down) (Very Hard)**

Languages spoken at home:

Would you like an interpreter? Yes / No

**Family history**

**Mother**’s name: Date of birth:

Country of birth: **Occupation**:

**Currently working**: Full time / Part time **Education**: primary / secondary / tertiary

Contact details (if different from child):

**Father**’s name: Date of birth:

Country of birth: **Occupation**:

**Currently working**: Full time / Part time **Education**: primary / secondary / tertiary

Contact details (if different from child):

**Name all siblings/other people living in or spending significant time in family home:**

Name Age Relationship to child/family Developmental concerns/ /mental health issues/other

Describe any other living arrangements for your child (e.g. weekends at another parent’s house, contact visits)

Have there been any stresses in the family, which you feel may have had some impact upon your child, e.g. divorce, separation, recent move (home, interstate), illness/ death in the family, any other issues?

**Any other information**:

*Thank you and we look forward to meeting you.*

**School Clinic Team**