**CAV UHB Neuro-Developmental Service**

**Parent/Carer Questionnaire**

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| **Child’s name:** | **Date of birth:** | |
| **Form completed by (name):** | **Date:** | |
| **Address your child lives at:** | | |
| **Telephone number:** | | |
| **Name of school/playgroup/nursery:** | | |
| **Which of the following professionals are involved with your child?** | | |
| **GP** |  | |
| **Community Paediatrician** |  | |
| **Health Visitor/ School Nurse** |  | |
| **Speech and Language Therapist** |  | |
| **Clinical Psychologist** |  | |
| **Educational Psychologist** |  | |
| **Portage/Early Years Teacher** |  | |
| **Other professionals** |  | |
| **Language(s) spoken at home**  (Please indicate child’s main language) |  | |
| **Background information** | | |
| **Who lives with your child?** | | |
| **Are there other people who also look after your child who do not live at your child’s address, who may also be able to provide information on your child’s difficulties?** (e.g., Child Minder, other relatives etc.) | | |
| **IS there any family history of the following?** | | |
| **Autism Spectrum Disorder or ADHD** | | |
| **Learning difficulties including specific difficulties such as dyslexia?** | | |
| **Mental health conditions e.g., anxiety, depression, psychoses, schizophrenia** | | |
| **Genetic conditions** | | |
| **Medical History** |  | |
| **Were there any problems during the pregnancy or birth of your child?** | | |
| **Has your child ever been admitted to hospital or been under review by a consultant? Yes/No. If YES please provide further details below:** | | |
| **Does your 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?** | | |
| **Are there any aspects of behaviour that are difficult to manage?** | | |
| **Are there any particular areas of strength?** | | |
| **Do you have concerns about any of the following areas?** | | |
| **Development/Learning**  Please mention if your child has learning difficulties/ has the child lost any skills or abilities. | **No concerns** | **Yes** (Please give details) |
| **Play** | **No concerns** | **Yes** (Please give details) |
| **Communication** | **No concerns** | **Yes** (e.g. language levels, both understanding and use of language, use of gesture, body language, facial expressions, tone of voice and eye contact) |
| **Social skills** | **No concerns** | **Yes** (e.g. level of interest in others, ability to seek and provide comfort, empathy, understanding of social rules such as turn taking) |
| **Concentration** | **No concerns** | **Yes** (e.g. difficulties with following instruction, with sustained mental effort, listening, organisation, losing things, being easily distracted, forgetful) |
| **Hyperactivity levels** | **No concerns** | **Yes** (e.g. fidgety, runs or climbs excessively, on the go, noisy in play/leisure activities, talks excessively, often leaves seat) |
| **Anxiety** | **No concerns** | **Yes** (Please give details) |
| **Sleeping** | **No concerns** | **Yes** (Please give details) |
| **Eating** | **No concerns** | **Yes** (Please give details) |
| **Sensory needs** | **No concerns** | **Yes** (Any unusual responses to sensory stimuli) |
| **Is there any risk to your child from themselves or others?** | **No concerns** | **Yes** (Please give details) |
| **If there is any further information you would like to provide, please do so in the space provided below:** | | |
|  | | |
| Thank you for taking the time to complete this questionnaire. If you have any questions about completing the form, please go back to the referrer who gave you the questionnaire. | | |