Naomi Campling
Psychologist

Suite 8/100 Burnett Street Buderim
PO Box 5115 Sunshine Coast MC QLD 4560
Ph 0491 119 185
Fax 07 5476 4108
Email admin@ncpsych.com.au
Web www.ncpsych.com.au

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	
Medicare number	Reference No:
Claimant's Name (usually parent) - required for Medicare online claiming	Reference No: Name: Date of Birth:
Questionnaire completed by	
Date completed	
Who referred you?	
General Practitioner/Paediatrician Name	

FAMILY INFORMATION

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

FATHER'S NAME: _____

DATE OF BIRTH: _____

RELATIONSHIP TO CHILD: Biological ☐ Adoptive ☐ Step ☐ Foster ☐ Other:

MOTHER'S NAME:_____

DATE OF BIRTH:_____

RELATIONSHIP TO CHILD: Biological ☐ Adoptive ☐ Step ☐ Foster ☐ Other:

OTHER PERSONS LIVING IN YOUR HOUSEHOLD:

First and Last Name	Relationship	DOB	Employer/ School	Position/ Grade In School

REASONS 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 you would most like help with.

YOUR CHILD

Please describe your child and their personality.

What are your child's strengths? Include topics / activities 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 Were there any 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 area:	
Communication Skills (eg. Speech and comprehension)	
Thinking Skills (ie. Ability to problem solve, attention span and concentration)	

Motor skills (eg. Running, jumping, writing, feeding)	
Self-care skills (eg. Feeding, grooming, dressing	
Social skills (eg. Ability to interact with others, start and maintain an appropriate interaction)	

Medical History

Current Health Status	
Medical Practitioners (current and past) Include Paediatricians, GP's and specialsists	
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	

Educational history *(for school-age children only who are being referred for assessment or school-related interventions)*

If possible, please provide copies of your child's most recent report card and IEP (if applicable).

Current school and grade	
Previous schools	
What are your current concerns (if any) about your child's schooling?	
Describe any additional support that your child receives at school, if any.	

Previous Support

Please describe any previous intervention or support that you have sought for your child. Please include the type of support and professionals involved and approximate dates.

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

EXPECTATIONS

Please outline what goals you have for therapy with your child.

Thank you for your time in completing this questionnaire. It will provide the psychologist with useful information for your session. Please bring the completed copy to your first session or return via email to admin@ncpsych.com.au