Parent Questionnaire

(Please complete and return prior to the clinic appointment)

The Sleep Cottage

2/83 Kareena Road, Miranda NSW 2228

Ph: (02) 9195 6677 Fax: (02) 9198 9511

E-mail: frontdesk@thesleepcottage.com.au

Personal Particulars:

Name of the child____________________________DOB____________________
Address____
Phone: Home____________________Mobile________________________
Childcare/ School details ____________________________________

Family details:

Parent 1 Name: ____
Contact details: Phone________________E-mail:________________________
Work: ____

Parent 2 Name: ____
Contact details: Phone________________E-mail:________________________
Work: ____

Please list all siblings/people living in or spending significant time in the family home:

Name	DOB / Age	Relationship	Development/ Mental health/ Medical issues

List of services involved in child's care:

Name	Position	Organisation	Contact details

Birth History:

Any problems during pregnancy____________________________________
____
Length of pregnancy____
Birth details -
Vaginal delivery ☐ Vacuum extraction ☐ Forceps extraction ☐ Caesarean ☐
Birth weight ____________________ Apgars: 1 min ______ 5 min ______
Did baby require any medical intervention after birth ________________________
____

General Medical History:
Any medical diagnosis / past history of hospitalisations / surgical interventions

Medications
Hearing Vision
Immunisations Allergies
Sleep

Diet

Bladder and bowel (Toilet training / Bed wetting/ Constipation/ soiling)

Please describe the main issues you wish to address at this appointment and what are your expectations of this assessment?

Please list details of any developmental/ behavioural concerns or any issues raised at the preschool/ school:

Please attach previous assessment reports from speech pathology/ occupational therapy/ psychologist/ preschool / school reports.

It would be valuable if the completed questionnaire is returned along with other relevant information prior to the clinic appointment. It would assist in timely and efficient completion of the medical appointment. The documents can either be returned via fax: (02) 9198 9511 or via e-mail: frontdesk@thesleepcottage.com.au with subject addressed with child's full name and DOB.

All information provided in this questionnaire will be confidential and will be stored in your child's medical records. Consent to exchange information with involved professionals to be completed on New Patient Intake Form to assist us for future correspondence and liaison as necessary.

We would also like to inform you that a paediatrician appointment is the starting point for the assessment process and it may involve attendance with other allied health professionals such as psychologist and/or speech pathologist and/or occupational therapist as indicated.

Questionnaire completed by ______________________________ Date__________
& relationship to the child ____________________________

****