**Today’ Date:**

**Name of person/s completing this form:**

**Child Information:**

Childs First Name:

Childs Last Name:

Child’s Age: (years) (months)

Date of Birth:

Position in Family (e.g. second eldest son; only child):

Year at School:

Child resides with (circle): Mother Father Both

Child’s Home Address:

Primary language of the home:

**Family Information:**

Mothers’ Name: Contact ph:

Mothers Age:

Mother’s Occupation:

Fathers’ Name: Contact ph:

Fathers Age:

Father’s Occupation:

Siblings Names (incl their ages):

Email Address for contact:

**School Information (if applicable):**

Teacher’s Name:

Name of School:

School Address:

School Phone Number:

Do you consent to your psychologist contacting the school teacher: Y / N

**Reason for requesting psychological therapy for your child:** (e.g. behavioural problems, difficulties at school, problems with mood, problems with anxiety or worry, aggression, concerns about development, other):

**Are these problems causing a significant impact at (circle if yes):** Home / School / Socially / All areas

**Developmental History**

Pregnancy & Birth – normal or complications? Please elaborate if complications occurred.

Birth weight:

**Early development**

Did your child meet all his/her developmental milestones at the appropriate time? Y / N - Early / Late

If early or later, please specify which milestones (e.g. walking, spoke first words etc):

1. Where there any early childhood health/medical problems? (hearing, vision, surgeries, serious illnesses, diagnoses):

 Are there any concerns with:

• Child’s vision: Y / N

• Child’s hearing: Y / N

Has this child ever been admitted to hospital:

Was your child’s language/speech development normal?

Can you describe your child’s early temperament?

• How much energy do they bring to situations?

• How flexible are they?

• How well does the child tolerate frustration?

 **Day care**

Did your child attend Day care? Y / N

• If yes, from what age did they attend Day care?

• How did they react to the separation?

• How many days per week did they attend?

• What feedback did you receive from Day care? (e.g., child’s strengths/weaknesses)

• Any significant problems/special education needs?

**Preschool**

1. Did your child attend pre-school? Y / N

• If yes, from what age did they attend pre-school?

• How did they react to the separation?

• How many days per week did they attend?

• What feedback did you receive from pre-school? (e.g., child’s strengths/weaknesses)

• Any significant problems/special education needs?

**Education:**

Current academic performance (e.g., average):

• Areas of difficulty:

• Areas of strength:

Current learning, behavioural or social problems at school/home:

The effectiveness of any learning/coping strategies that have been tried previously:

Results of any previous testing (IQ, academic):

Teacher feedback (Please state any comments from your child’s teacher which you feel is relevant)

Other services involved with your child at present: (e.g., DoCS, school counsellor, speech therapist,

occupational therapist)

Any other comments’ regarding your child’s learning experiences?

**How would you describe your child’s *current* :**

Has your child been able to develop age-appropriate peer-relationships? Y N

Relationship with peers: (e.g., very social, independent, passive, shy)

Relationship with teacher:

Relationship with parents and siblings:

Physical Health:

Mental Health (does your child experience anxiety, anger, depression, frustration?)

What are your child’s hobbies/interests?

In what extra activities does your child participate?

Any adjustment issues or social stressors/concerns:

1. **Family background:**

Significant life events: (e.g. divorce, separation, death of a close friend or relative, re-location of family, natural disaster, other significant trauma)

Drug and alcohol problems in family: (History of parental medication/drug use that may affect the child’s learning or may have affected it in the past)

Family history of learning problems, giftedness, developmental delays, attentional problems or autism?

Family history of mental illness: (e.g., anxiety, depression)

Current medication: (If so, please state prescriber, medication name, dosage, effects, any other comments)

1. **Past Psychological history:**

Has your child seen a psychologist or psychiatrist before? If so, what for, and what was the outcome?

**Please add any other comments, concerns, observations regarding your child you believe may be relevant. Thank you.**