

**Getting to know your child**

(6 - 18 years old)

***Please fill out this form and bring it to your appointment. We can help you fill it out at the appointment if needed.***

**Your name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Must be the legal guardian) Date: \_\_\_\_\_\_\_\_\_\_\_­**

**Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Best days for appointments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FAMILY:**

Parent/ Carer 1: Parent/ Carer 2:

Who lives at home? (Please include age of brothers/ sisters)

Are there any guardianship, custody or access arrangements involving the child?

Has your family experienced any stressful events (e.g. death in family, separation, family violence etc.)?

Has anyone in your family had speech, language or learning problems?

What language/s do you speak at home?

**MY CHILD:**

**Name: Date of birth:**

Things my child is good at/ likes doing:

What are your concerns about your child?





**OTHER COMMUNITY SUPPORTS:**

GP Name and Practice:

Name of School: Year Level:

Does your child see a Paediatrician/ Other Professionals?

Does your child participate in activities outside of school?

**EARLY DEVELOPMENT:**

Were there any difficulties with your pregnancy or your child’s birth?

Was your child delayed in any areas growing up? e.g. walking, talking, eating



**HEALTH:**

Has your child had any illnesses, accidents or operations?

Does your child have any allergies? Any ear infections / frequent colds:

Does your child take any medications?

Are there any concerns about hearing or vision?

Does your child go to the dentist?



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**YOUR CHILD’S DEVELOPMENT:**

Do you have any concerns about your child’s …….

* Eating habits/weight/growth?

* Communication skills?
* Using hands for everyday activities (eg. handwriting, cutlery)?
* Learning at school?
* Social interaction and friendships?
* Participation in physical activity? (including balance/coordination, tripping, in-toeing)
* Behaviour, emotions or self-esteem?
* Sleeping habits?

Does your child have any pain?







Other comments/ things you want us to know**:**

**OFFICE USE ONLY:** Discussed and provided family with copy of:

🞏 Client feedback 🞏 Client rights and responsibilities 🞏 Keeping your information private

🞏 Using an advocate 🞏 Infection Control 🞏 Australian Charter of Health Care Rights (Vic)

Brochures:

🞏 Our Services 🞏 Your Community Health Dental Services 🞏 Your Community Health Membership form

🞏 Alerts updated on Trakcare

Would you like to work with us to develop a personalised health and wellbeing plan? Y/N