Royal Free London ***NHS .***

NHS Foundation Trust

***PARENTS TO FILL AND RETURN PLEASE***

**BARNET CHILD DEVELOPMENT SERVICE**

**PRE-CLINIC INFORMATION ABOUT CHILD**

Please fill in as much of this form as you can. Not all areas will be relevant. More information helps us to improve our

assessment. Every reference to ‘child’ is taken to mean ‘child or young person’.

We need to know about your own concerns as well as those of professionals, which may be different.

We also need to know about your child’s strengths and what they are best at, so that we can get a clear picture of

the whole child and their situation.

Filling this in before you come for your appointment gives you time to think and to check out the details. If you need more space please use the back page of this form.

**Thank you for your time. We look forward to meeting you.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Child’s Surname:**  **First Name:** |  |  | **Gender:**  *(tick as applicable)*  **NHS NUMBER:** | Male □  Female □ |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date of Birth:** |  |  | **Age:** |  |

|  |  |
| --- | --- |
| **Address:**  **POSTCODE:** |  |

|  |  |
| --- | --- |
| **Telephone:** |  |

|  |  |
| --- | --- |
| **Email :** |  |

|  |  |
| --- | --- |
| **GP:** |  |

|  |  |
| --- | --- |
| **School / Nursery:** |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Language(s) spoken at home:** |  |  | **Religion:** |  |

|  |  |
| --- | --- |
| **Name of person completing this sheet:**  **Relationship to child:**  **Date:** |  |

|  |
| --- |
| Do you know who **referred** your child to our service, and **why**? |
|  |
| **Parent’s / Carer’s / Child’s concerns:**  *(Please write down what worries you, any questions you want to ask in clinic, and what you hope to get from the assessment)* |
|  |

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| --- |
| **Nurseries and Schools attended** (with dates): |
|  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Professionals Involved:**  *(Please list any specialist clinics, therapists, teachers or others who have already seen your child)* | | | |
| Name and Profession: | Where do you see them: | Last seen: | Next appointment: |
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**ANTENATAL (PREGNANCY) HISTORY**

|  |  |
| --- | --- |
| Did mother have any illness during pregnancy?  Was there any bleeding?  Was there a problem on any of the scans?  Did mother take any tablets / medication?  Any other problem during pregnancy?  *(please give details)* |  |

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| --- | --- |
| Cigarettes / day during pregnancy: |  |

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| --- | --- |
| Alcohol intake: |  |

|  |  |
| --- | --- |
| Other drugs: |  |

**BIRTH**

|  |  |
| --- | --- |
| **Place of Birth:** |  |
| **Birth weight:** |  |

|  |  |  |
| --- | --- | --- |
| **Pregnancy duration:** | Full Term | Premature  *(by how many weeks?)* |

|  |  |  |
| --- | --- | --- |
| **Labour:** | Spontaneous onset | Induced |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Delivery:** | Normal | Breech | Forceps | Ventouse | Caesarean |
| Any problems with the delivery, or with the health of the baby at birth? | | | | | |
|  | | | | | |

**NEWBORN PERIOD AND EARLY INFANCY**

|  |  |
| --- | --- |
| Did baby need help with breathing after birth? |  |
| Did baby need Special Care? |  |
| Any problems in the newborn period? *(please give details)* | |
|  | |
| How old was baby when you took him/her home? |  |

**EARLY FEEDING AND WEANING**

|  |  |
| --- | --- |
| Any feeding problems early on? | |
|  | |
| If breast fed, until what age? |  |
| Age at which **solids** introduced? |  |

**MEDICAL HISTORY**

|  |
| --- |
| Please write down any **diagnosis** or **condition** your child is known to have, and age at diagnosis: |
|  |

**Hospital visits:**

|  |
| --- |
| Please write down any details you remember *(when, what for, which hospital, which department or ward, etc)*: |
|  |

**Other illnesses or accidents:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Has child had? | Measles | Mumps | Chickenpox | Rubella  (German measles) | TB |
| Other illnesses, accidents or complications: | | | | | |
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**Immunisations:**

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| --- |
| Please write down any jabs you know your child has **NOT** had, including the reasons: |
|  |

**GENERAL HEALTH**

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| --- | --- | --- | --- |
| Please indicate if your child has: | | | |
| Frequent cough | Asthma | Eczema or other skin problem | Bowel problem |
| Urine infections or other urine or kidney problem | Fits, faints or funny turns | Headaches | Heart problem |
| Problem with Teeth |  |  |  |
| Any other medical or mental health problem? | | | |
| Please give details: | | | |
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| --- | --- |
| Most recent visit to dentist: |  |

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| --- |
| **Medication** including doses: |
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| --- |
| **Allergies** to medication or to anything else *(please describe type of reaction)*: |
|  |

**FAMILY**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Birth mother** *(name)*: | |  | |  | Date of birth: | |  |
| Health: | |  | |  | Occupation: | |  |
| Living with child? | Yes / No | | If not, how frequent is contact? | | |  | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Birth father** *(name)*: | |  | |  | Date of birth: | |  |
| Health: | |  | |  | Occupation: | |  |
| Living with child? | Yes / No | | If not, how frequent is contact? | | |  | |

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| --- | --- |
| Are birth parents related eg cousins | Yes / No |

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| --- | --- | --- | --- |
| Details of everyone else living in the home: | | | |
| Name | Date of birth | Relationship to child | Health |
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| --- |
| Are there any brothers or sisters who live elsewhere? |
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| Have you – or anyone else in the close family – had any miscarriages, stillbirths, or had a young child who died? |
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| --- | --- |
| Please write down if anyone in the family has had problems with any of the following? | |
| Hearing |  |
| Vision |  |
| Speech |  |
| Learning |  |
| Epilepsy, fits or funny turns |  |
| Muscle problems |  |
| Physical Disability |  |
| Mental Health problem |  |
| Other health problems (*please give details*): | |
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| --- |
| Has anyone in the family needed extra help at school or attended a special school? |
|  |

**HOUSING**

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| --- | --- | --- | --- | --- |
| Please write down any housing issues: | | | | |
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| Does anyone smoke in the home? | YES NO |  | Are there any pets?  (*please give details*) |  |

**SUPPORT AND INFORMATION**

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| --- | --- |
| Do you get any **special benefits** eg DLA: | YES NO |
| Does your child have a **social worker**: | YES NO |
| Do you use **respite care or short breaks**: | YES NO |
| Where do you get your **support** from (eg grandparents etc): | |
|  | |

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| --- |
| Do you get the **support you need** to care for your child? If not, please say what support you need: |
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|  |
| --- |
| Do you have enough **information** about the services available for your child? If not, please say what you want: |
|  |

**DEVELOPMENT & CURRENT FUNCTIONING**

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| --- |
| Please describe your child’s **personality and temperament**, what he/she enjoys most, how he/she plays: |
|  |

**Movement & Posture**

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| --- | --- |
| How does your child usually **move** around?  *(carried, crawl, bottomshuffle, walk, run etc)* |  |
| Please list any **equipment** needed to assist with movements or posture: |  |
| Please write down any **worries** about movement, posture, balance or coordination: |  |

|  |  |  |
| --- | --- | --- |
| **Can he / she:** |  | **Age achieved** (*approximate*) |
| Sit without support | YES NO |  |
| Walk alone | YES NO |  |
| Run | YES NO |  |
| Jump with feet together | YES NO |  |
| Climb stairs | YES NO |  |
| Kick a ball | YES NO |  |
| Pedal a bike | YES NO |  |
| Get up easily from floor without using hands | YES NO |  |

**Personal Care & Hand Function**

|  |  |
| --- | --- |
| Which hand does your child use most: | RIGHT LEFT BOTH UNSURE |

**Feeding**

|  |  |  |
| --- | --- | --- |
| **Can he / she:** |  | **Age achieved** (*approximate*) |
| **Hold** his / her own bottle or cup | YES NO |  |
| Feed him/her self using **fingers** | YES NO |  |
| Feed him/her self using **spoon** | YES NO |  |
| Use **fork** | YES NO |  |
| Use **2 items of cutlery together** (fork & spoon) | YES NO |  |
| **Bite** a small piece from a larger item of food | YES NO |  |
| **Chew** properly | YES NO |  |

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| --- |
| Please write down any **difficulties** with feeding, chewing, swallowing etc. |
|  |
| Does your child require any **special diet** or feed? *(please give details)* |
|  |

**Dressing & Washing**

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| --- | --- | --- |
| **Can he / she:** |  | **Please give details** |
| **Assist** with dressing and washing *(eg hold out foot; push arm through sleeve)* | YES NO |  |
| **Remove** an item of clothing | YES NO |  |
| **Replace** an item of clothing | YES NO |  |
| **Undress** independently | YES NO |  |
| **Dress** independently | YES NO |  |
| Manage **fastenings**  *velcro, zip, popper, button etc)* | YES NO |  |

**Continence (ie bladder & bowel control)**

|  |  |  |
| --- | --- | --- |
| **Can he / she:** |  | **Age achieved** (*approximate*) |
| Indicate when his/her nappy needs changing | YES NO |  |
| Ask for potty or toilet | YES NO |  |
| Go to potty or toilet independently to pass urine | YES NO |  |
| Request help for wiping | YES NO |  |
| Wipe his/her own bottom after passing stool (poo) | YES NO |  |
| Get through a **day without toileting ‘accidents’** | YES NO |  |
| Get through a **week** without toileting ‘accidents’ | YES NO |  |

|  |
| --- |
| Please write down any **difficulties** with hand function or personal care skills (feeding, dressing, washing, toileting) |
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**Hearing**

|  |  |  |  |
| --- | --- | --- | --- |
| Did your child have a **Newborn Hearing test?** | YES NO | Where / When done and **Result** |  |

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| --- |
| Please write down any **concerns about hearing** and any other tests your child has had: |
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**Vision**

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| --- |
| Please write down any **concerns about vision** and any tests your child has had: |
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**Speech, Language and Social Communication**

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| How does your child usually **communicate** (*eg. Speech, signing, gestures, Picture Exchange etc*): |
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| --- | --- |
| If child uses speech… | |
| Is this **clear** for a stranger to understand? | YES NO |
| Is there anything unusual about the quality or tone of speech? *(please give details)* |  |

|  |  |  |
| --- | --- | --- |
| **Does he / she:** |  | *(add comments)* |
| Indicate a clear **Yes / No** response | YES NO |  |
| **Point** to **ask** for something | YES NO |  |
| Point to **show** you something | YES NO |  |
| **Bring** something to show you | YES NO |  |
| **Show interest** in what you are doing | YES NO |  |
| Try to **copy** what you do | YES NO |  |
| Have a special **friend** | YES NO |  |
| Enjoy cuddles | YES NO |  |

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| --- | --- |
| Please describe **any pretend / creative / imaginative play** |  |
| Please describe how your child **plays with other children** and the sorts of things they do together |  |
| How does your child react if you are **hurt or upset** |  |
| How does your child generally respond to **other people’s emotions** |  |

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| --- |
| Please give examples of your child’s **best skills in understanding** what you say: |
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| --- |
| Please give examples of your child’s **best skills** in speech and communication: |
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|  |
| --- |
| Please write down any **concerns** with speech, language or communication: |
|  |

**Learning**

|  |  |  |
| --- | --- | --- |
|  |  | *(please add comments)* |
| Is your child **learning new things** all the time | YES NO |  |
| Do you think he/she has **LOST** any developmental skills | YES NO |  |
| Does he / she get **extra help** at school / nursery  *(please give details below)* | YES NO |  |
| Does he / she have an **individual education plan** | YES NO |  |
| Does he / she have an **Education, Health & Care Plan (EHCP)** | YES NO |  |

|  |
| --- |
| What are your child’s **best skills with learning**  *(eg remembering routes; counting; building; puzzles; computer; reading; music; maths etc)* |
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|  |
| --- |
| Please write down any **concerns** about your child’s learning or developmental progress: |
|  |

**Behaviour:**

|  |
| --- |
| Please give examples of **best behaviour:** |
|  |

|  |
| --- |
| Please describe any **unusual habits or mannerisms:** |
|  |

|  |
| --- |
| Are there any **repetitive or unusual aspects** to play:  *Eg. Feeling or looking at things in an unusual way, lining toys up repeatedly, playing with wheels rather than car* |
|  |
| How does your child **react to changes in routine:** |
|  |

|  |
| --- |
| Does he/she have any **rituals** of behaviour:  *Eg. Having to do things in a particular order, sit in a particular place etc* |
|  |

|  |
| --- |
| Does he/she show any **unusual sensitivities**  *Eg to household noises, or to particular objects / situations / smells* |
|  |

|  |
| --- |
| Please write down any other **concerns about behaviour:** |
|  |

**Sleep**

|  |  |
| --- | --- |
| Does child have his / her **own bed** or cot |  |
| Does your child have his / her **own room** to sleep |  |
| What time (on a typical day) does he / she **go to bed** |  |
| What time (on a typical day) does he / she **go to sleep** |  |
| What time (on a typical day) does he / she **wake up** |  |
| How many times during the night does he/she wake up, and for how long? |  |
| **Total hours of sleep** per night |  |
| Daytime sleep (**naps**) |  |

|  |
| --- |
| Any other comments or **concerns about sleep** pattern |
|  |
| **Please use this page to write anything else you think it is important for us to know about your child, your family or your circumstances:** |
|  |

**THANK YOU VERY MUCH FOR TAKING THE TIME TO COMPLETE THIS FORM.**

**THE INFORMATION WILL HELP US TO HELP YOUR CHILD.**

The form should be returned to:

Intake Coordinator,

Barnet Child Development Service

Westgate 3**rd**floor

Edgware Community Hospital

Burnt Oak Broadway

Edgware HA8 0AD

or via email to : [rf-tr.childdevreferrals@nhs.net](mailto:rf-tr.childdevreferrals@nhs.net)

**PLEASE ALSO SEND COPIES OF ANY SPECIALIST REPORTS OR ASSESSMENTS ALREADY DONE**

(This questionnaire has been adapted from the version available on the website of the British Academy for Childhood Disability July 2016)