

STRICTLY PRIVATE AND CONFIDENTIAL

**PRE-INTERVIEW QUESTIONNAIRE FORM FOR CHILDREN TO BE
COMPLETED BY THE PRIMARY CAREGIVER**

Prior to your intake session, please take some time to fill in this form about your child. Filling in the form now helps us to reduce the time and cost of gathering information prior to the commencement of therapy.

Much of the information requested is highly personal. Be assured that client records are strictly confidential. If for any reason you do not wish to fill in this form, feel free not to and we will go through the form in the intake session. However, this may result in a follow-up intake session being scheduled.

Once completed, please email back to Life Choice or bring the form with you to the intake session.

This questionnaire was developed with reference to the Multimodal Life History Inventory, Lazarus & Lazarus (1991) and the Connors-March Developmental Questionnaire, Connors & March, (1994)



Date: _____

NDIS / Private

1. General Information

Name of Child: _____ Date of Birth: _____

Gender: _____

Primary Caregivers' Full Name:

Who does the child currently live with?

Name	Age	Relationship

Name of school/day care: _____ Grade: _____

Child's current diagnoses (if applicable):

2. Reason for Attending

Are you requiring a diagnostic assessment? Yes / No

If yes, what diagnosis is being investigated? e.g. ASD, ADHD, Intellectual Impairment, Specific Learning Disability etc.

Please list NDIS goals (if applicable):

Please state briefly symptoms and/or concerns you wish to address during therapy sessions:



When did these problems begin?

3. Previous/Current Help Sought

Please describe historical or current services accessed:

Type of therapy	Name of therapist	Dates accessed

4. Personal History

DEVELOPMENTAL HISTORY

Please answer these questions to the best of your knowledge about your child.

Was their birth....? Natural / Caesarean / Forceps delivery

Other Complications with pregnancy/birth? please specify

Motor development (sitting, crawling, walking)	Average / Early / Late
Speech and language	Average / Early / Late
Self-help skills	Average / Early / Late
Bowel trained	Average / Early / Late
Bladder trained	Average / Early / Late

Any additional developmental concerns:



What is your child's main form of communication e.g. speech, noises, gestures:

FAMILY HISTORY

Parents and siblings names and ages:

Has a member of the child's family ever had psychological problems, for example, anxiety, depression, ADHD, ASD, learning problems, etc? YES/NO

If yes, please specify

Has a member of your family ever attempted or completed suicide? YES/NO

Any other relevant history

MEDICAL HISTORY

Please describe any current concerns that you have about your child's physical health.

Please describe any significant illnesses/hospitalisations.



Please describe any significant medical problems that apply to your family.

Does your child have issues with sleep? If yes, specify

Does your child have issues with eating? If yes, specify

Is your child currently taking any medication? YES/NO

If YES, please list:

Medication	Reason

ADDITIONAL INFORMATION

Does your child have any hobbies or interests? Please describe

What are your child's strengths?

Is there anything that will make your child more comfortable in therapy? (Please feel free to bring comfort items to session e.g. weighted blankets, soft toys, fidgets, jewellery)



Thank-you for completing this questionnaire. Please return via email, drop off at reception or bring it with you to your intake session.

