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| **Background information sheet** |
| **Child’s first name(s):** | **Child’s last name:** | **Child’s date of birth:** |
| **Child’s preferred name(s) (if applicable):** | **Child’s ethnicity:** |
| **Your name and relationship to child:** | **Who holds parental responsibility?** *(mother, father, other?)* | **Date of completion:** |
| **Birth mother name:** | **Birth father name:** | **Who is the main carer for the child?** |
| **Parent/ main carer concerns:** Please include what you have tried to do to support your child already |
| **Please provide details of any professionals working with your child?** *(eg health visitor, social worker)* |
| **Family history** |
| **Please provide details of who lives at home:****Family medical history:** Please detail any medical history for yourself/ birth parents, siblings and extended family/ significant family members *(for example any relevant physical ill health, mental or learning difficulties)* |
| **Have there been any upsetting or traumatic, physical or emotional events for you and / or your child**? please tick *(and add to if necessary),* we will sensitively discuss at your child’s first appointment.Death Illness Domestic violenceDivorce Separation Significant accidents |
| **Child’s medical history** |
| **Did you/ birth mother, take any medicines / drugs *(including illegal drugs)/* smoke cigarettes or consume alcohol during pregnancy?** if yes please provide details: **Were there any complications and/ or illnesses in pregnancy?** If yes please provide details |
| **Please provide any relevant details about your child’s birth** *for example; born prematurely, difficulties with delivery, needed special care, low birth weight***How would you describe your child as a baby?** *For example, did you have any concerns with feeding, sleeping, settling into routines, growth?***Did you experience any difficulties forming a bond with your child?** |
| **What medications is your child currently prescribed?** Please detail name, dose and how often this is taken, please include herbal medicines and vitamins?  |
| **Please detail any additional information you may feel relevant** Please consider significant/ reoccurring illnesses, accidents, relevant medical test and / investigations. |
| **Has your child received all of their immunisations?** If not please detail why |
| **Do you have concerns about your child’s development?** ***if* *yes***, please complete this section, ***if no*** please state N/A and skip to next section**what age did your child?**Please state ‘not yet’ if they are not yet able to do this

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| **Start smiling?**  | **Sit without support?** |
| **Take their first steps?** | **Say their first words?** |
| **use two-word phases?** |  |

**Do you think your child is learning new things? / Has your child started to gain a new skill then appear to have lost it? If yes, please provide further information?****Do you have any worries about their movement?** *(such as crawling, walking, running, balance, co-ordination)***Do you have any worries about how your child uses their hands?***For example, skills such feeding themselves, brushing their teeth, using buttons/ zips, tying their shoelaces, writing or drawing?* |
| **Are there any current or past concerns regarding hearing and vision for your child?** Please provide details of any hearing and/ or sight tests your child has received. |
| **Communication; Speech and Language****Do you have any worries about your child’s speech or communication?** ***If yes*** please complete below, ***if no***please state N/A and skip to social development**Please detail how your child communicates with you?** Please consider if they are able to follow instructions, get your attention, give eye contact, if you or other people can understand them and how?**Has your child had any speech assessments?** |
| **Social development, play and relationships:****How does your child interact (get on) with other children or adults?** Please consider if they can make and keep friends easily? do they find it easier to relate to adults or younger/ older children? how they get on with their siblings?**Please details how your child likes to play** Please consider types of toys or games, use of pretend play, are you able to re-direct their interest?**Please detail any of relevant information to aid an assessment** Please consider factors such as any unusual habits and/ or routines, reactions to change, noise, smells and textures.  |
| **Behaviour****Do you have any worries about your child’s behaviour?** ***If yes*** please complete below, ***if no***please state N/A and skip to education**How would you describe your child’s behaviour?** Please consider if they get unusually angry and/ or have out bursts, are they sadder than other children, do they harm themselves or others in any way? Would they feel remorse for any poor behaviour?**How do you manage your child’s behaviour?** Please consider what works well and what does not |
| **Education****Is your child in school or nursery? *If yes*** please complete below, ***if no***please state N/A and skip to education *(If too young please state N/A, if excluded please state and complete for last school placement)***Please detail any concerns raised by your child’s school/ nursery?****Please detail any support your child is receiving in school or nursery?** |
| **Strengths**Please detail here anything you would like to share on what your child does well and who they are as a person |

Thank you very much - we appreciate the time you have taken to complete this form. This information will enable the clinician to tailor the first appointment to you and your child’s needs and request any further information that may support the appointment beforehand.