



Parental Pre-Clinic Questionnaire

For children aged between 2 to 3 years 11 months

Please return your completed forms (Parental and School) to Kingsbridge Private Hospital prior to your appointment.
info@kingsbridgehealthcaregroup.com

Child's Name	
Surname:	Forename(s):
Current Address:	Date of Birth:
Sex at Birth:	Gender Identity:
Primary Language:	
Other languages spoken at home:	

Parent/Guardian Details	
Surname:	Surname:
Forename(s):	Forename(s):
Current Address:	Current Address:
Contact No:	Contact No:
Email:	Email:

Consent for Contact

In preparation for your child's assessment, it is sometimes necessary to obtain additional information from other individuals or agencies. Please complete and sign the following form as stating your permission to contact those who are/have been involved with your child.

GP Details for Child	
GP Name:	
GP Address:	
Contact No:	
I give permission for the above to be contacted: Y N	

Education	
Name of Current School:	
Dates Attended:	
Address of Current School:	
Contact No:	Email:
I give permission for the above to be contacted: Y N	

Hospitals/Clinics/Local Mental Health Services	
Clinician's Name:	
Dates Attended:	
Name of Clinic / Hospital:	
Contact No:	Email:
I give permission for the above to be contacted: Y N	

Background Information

	Name	Date of Birth	Title (Mr/Mrs/Miss/Ms/Dr/Mx etc.)	Details of any developmental difficulties (e.g., Autism, ADHD, speech delay, dyslexia, or mental health difficulties)
Biological Mother				
Biological Father				
Name(s) of caregiving parents (if different from above):				
Details of developmental or mental health problems within the extended family:				

	Name of Sibling	Date of Birth	Age	Sex	Relationship (e.g., full sibling, adoptive sibling, half sibling)	Details of any developmental difficulties (e.g., Autism, ADHD, speech delay, dyslexia, or mental health difficulties)
1.						
2.						
3.						
4.						
5.						

Education and Schooling

Please provide as much information as possible about toddler groups, nurseries, schools, and further education:

	Name of nursery/ school/ college/ university	Type of school (e.g., mainstream, independent, special school)	Age when attended		Additional support? If yes, please provide details	Grades Achieved (e.g. GCSEs)
			From (_Years_Months)	To (_Years_Months)		
1.						
2.						
3.						
4.						

Has your child ever received an Individual Education Plan (IEP), Statement of Special Educational Needs (SEN), or Education Health Care Plan (EHCP)?		Y	N
Age when Stated (___Years, ___Months)	Details of statement (e.g., hours per week, focus of support):		

Existing Diagnoses			
Diagnosis	Age when diagnosed (___Years, ___Months)	Type of professional who made diagnosis (e.g., psychologist, psychiatrist, pediatrician)	Any additional information, e.g., medication

Pregnancy and birth

Were there any complications during pregnancy
(e.g., any infections/viral illnesses/hospital admissions/other)?
If yes, please provide details:

Y N

Were any medications taken during pregnancy?

If yes, please provide details on the medication, dose, frequency, and during which trimester:

Name of medication	Dose	Which trimester(s)? Trimester 1 (1-12 weeks) Trimester 2 (13-26 weeks) Trimester 3 (27 - end of pregnancy)	Any other details

Did the mother of the child do any of the following activities during pregnancy?

	Trimester 1 (1 - 12 weeks)	Trimester 2 (13 - 26 weeks)	Trimester 3 (27 weeks - end of pregnancy)
Alcohol	Y N	Y N	Y N

Please provide details (e.g., frequency & amount):

Tobacco Products	Y N	Y N	Y N
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Please provide details (e.g., frequency & amount):

Recreational Drugs	Y N	Y N	Y N
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Please provide details (e.g., frequency & amount):

Maternal Age		Paternal Age	
Age of mother at time of birth, years _____		Age of father at time of birth, years _____	
Gestation			
When did the mother of the child go into labour? Weeks _____			
How was the baby delivered? (Please provide details in box)			
Vaginal		C-Sectional	
Forceps: Y N DK		Emergency: Y N DK	
Vacuum: Y N DK		Planned: Y N DK	
Birth Weight			
What was the baby's weight at birth?			
Any complications during or immediately following birth? If yes, please provide details:			
Newborn Period			
Did the baby have any major problems in the newborn period (0-30 days of life)?v			

Daily Living, Sensory and Motor Functioning

Does your child have difficulties managing basic activities of daily living? e.g. such as dressing, feeding and self-care.

Has your child ever had difficulties with fine motor skills (e.g., doing up buttons, writing or playing video games) or gross motor skills (e.g., walking, running, kicking or throwing a ball)?

Does your child have any sensory processing difficulties? (e.g., touch, hearing, taste, smell, sight, internal sense of body awareness, and/or movement).

Current Concerns

Please tell us about your current concerns in relation to your child's behaviour or development:

Non-verbal behaviours

How does your child communicate non-verbally?
(Include examples of how they use their eye contact, whether they smile in response to others, and whether they show a range of facial expressions)

Peer Relationships

How does your child play with others?

(Include examples of whether they show interest in other children and how they respond to the approaches of other children)

Shared Enjoyment

Does your child seek to share enjoyment with you or others?

(Include examples of showing things of interest to them, offering to share with others, and what kinds of things make them happy or excited and how they will show this)

Reciprocity

How does your child interact with others?

(Include examples of how they let you know they want something, how they offer comfort, whether they use eye contact and gestures and whether their facial expressions seem appropriate to the situation)

Language & Gesture

Does your child use gesture to communicate?

(Include examples of whether they point to express interest, whether they nod and shake their head to communicate yes/no and whether they use other common gestures such as waving goodbye or clapping)

Social Play

Does your child engage in imitative or imaginative play?

(Include examples of whether they copy your behaviours, whether they play pretend games, if their play varies from day-to-day and whether they can initiate and take part in games such as 'Ring A Ring O'Roses' or 'Peek-a-Boo')

Please only answer the next two sections (Conversation & Speech) if your child or young person uses at least three-word phrases on a daily basis that are comprehensible to other people:

Conversation (focus on whether this has ever been a difficulty for your child)

How does your child engage in conversation?

(Include examples of whether they will engage in and initiate 'small talk', how they will respond if you say something without using a direct question and whether they will bring up appropriate topics)

Speech (focus on whether this has ever been a difficulty for your child)

How does your child use the words they have?

(Include examples of phrases they might use, whether these phrases are 'odd' in quality, whether their speech varies or is repetitive and whether they use statements or questions that could be considered socially inappropriate)

Interests (focus on whether this has ever been a difficulty for your child)

What are your child's interests?

(Include examples of whether any of their interests are unusual in nature, e.g., metal objects, lights, whether they have interests that are unusual in their intensity and whether any of these interests interfere with them doing other things)

Routines & Rituals (focus on whether this has ever been a difficulty for your child)

Does your child engage in any routines or rituals?

(Include examples of verbal rituals, e.g., having to say the same thing over and over again in the same way, behavioural rituals, e.g., an insistence in doing things in a particular way or order, or compulsions, e.g., having to place objects in a certain way)

Motor Mannerisms (focus on whether this has ever been a difficulty for your child)

Does your child have any hand/finger or body mannerisms?

(Include examples of whether they exhibit finger twisting, hand stimming, or other whole-body movements such as spinning or bouncing repeatedly, and what might happen if you try to get them to stop)

Preoccupations (focus on whether this has ever been a difficulty for your child)

Does your child have any unusual sensory interests?
(Include examples of whether they collect or gather certain objects, whether they seem particularly interested in or aversive to specific sights, textures, sounds, tastes or smells of things or people, and whether they show an interest in certain parts of objects, e.g. the wheels of a toy car)

Developmental Milestones

Age Difficulties First Noticed (in months)	
Age of First Single Words (in months)	
Age of First Phrases (in months)	
Age First Walked Unaided (in months)	

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Thank you for taking the time to complete this form.