



## **HEARING:**

Parental concerns re hearing or listening/following instructions or language

Yes/No

Any history of ear discharge, ear infections, recurrent or chronic otitis media Yes/No

Does your child not seem to understand/respond to simple instructions?

Yes/No

Conduct ear examination

Audiometry required Yes/No

## **IDENTIFIED ISSUES:**

## **ACTIONS:**

## **ORAL HEALTH:**

Has your child visited a dentist? Yes/No

Is your child a thumb/finger sucker? Yes/No

Do you have any concerns re your child's teeth Yes/No

Do you give your child fluoride tablets? Yes/No

Examine teeth and gums

Are gums pink? Yes/No

How often does your child brush their teeth?

## **IDENTIFIED ISSUES:**

## **ACTIONS:**

## **TOILETING:**

Does your child wet their bed? Yes/No

Is your child fully toilet trained? Yes/No

Does your child need assistance to go to the toilet? Yes/No

Does your child have a history of urine infections? Yes/No

Is there a family history of any urinary/kidney problems? Yes/No

Does your child get constipated? Yes/No

Has your child been treated for constipation In the past? Yes/No

Has your child had any faecal incontinence? Yes/No

## **IDENTIFIED ISSUES:**

## **ACTIONS:**

## **EATING HABITS:**

Does your child have a good appetite?	Yes/No
Do you eat foods from all 5 food groups?	Yes/No
Does your child drink water?	Yes/No
Does your child eat a lot of high sugar content/processed foods?	Yes/No
Have you any concerns re your child's diet?	Yes/No

## **IDENTIFIED ISSUES:**

## **ACTIONS:**

## **PHYSICAL ACTIVITY:**

Is your child usually active and energetic?	Yes/No
Does your child spend a lot of time watching television?	Yes/No
Do they play outside on a daily basis?	Yes/No
Can your child swim?	Yes/No

## **IDENTIFIED ISSUES:**

## **ACTIONS:**

## **SPEECH**

Do you have any concerns re your child's speech?	Yes/No
Does your child speak only in short sentences?	Yes/No
Do other adults & children have difficulty understanding you child's speech?	Yes/No
Does your child stutter?	Yes/No
Does your child use a variety of words?	Yes/No
Do they understand directions?	Yes/No
Do they speak clearly?	Yes/No
Do they take part in conversations?	Yes/No

## **IDENTIFIED ISSUES:**

## **OUTCOMES:**

## **FINE & GROSS MOTOR SKILLS**

Can your child walk alone up & down stairs 1 foot/step?	Yes/No
Can your child ride a tricycle?	Yes/No
Can your child catch, throw, bounce and kick a ball?	Yes/No
Can they stand, walk and run on tiptoe?	Yes/No
Can they climb playground ladders & other equipment easily?	Yes/No
Can they hold a pencil between thumb & 3 other fingers?	Yes/No
Can they brush their teeth with supervision?	Yes/No
Can they wipe after using the toilet?	
Yes/No	
Can they dress and undress?	Yes/No
Can your child build a rocket, stairs and mountain using blocks?	Yes/No
Can they copy crosses & letters V, H, & O?	Yes/No
Can they cut out a square? (using scissors provided)	

**IDENTIFIED ISSUES:**

**OUTCOMES:**

## **SOCIAL & INTELLECTUAL**

Can they give first & last name and know their age?	Yes/No
Can they play games in groups with simple rules?	Yes/No
Can they do up buttons, put on socks and shoes?	Yes/No
Can they count to 5?	Yes/No
Can they name 4 primary colours?	Yes/No

**IDENTIFIED ISSUES:**

**OUTCOMES:**

## **BEHAVIOUR & MOOD**

Does your child sleep well?	Yes/No
Does your child wake up tired?	Yes/No
Can your child be separated from main care giver without distress?	Yes/No

**IDENTIFIED ISSUES:**

**OUTCOMES:**

Patient History:

Family and environment factors:

Family relationships:

Care arrangements:

Other:

Medical and social history:

Paediatrician:

Previous presentation:

Other:

Lifestyle risk factors:

Eating habits:

Physical activity/inactivity:

Other:

Patients overall health status:

Health issues identified and discussed with  
the patient's parent or guardian

Recommended intervention and/or  
referrals

GP or Practice Nurse:

Date: