Change for Life

Child Enquiry Form (School-Aged Children)

Date:

Full Name: _____ **DOB:** _____ **Age:** _____ **Gender:**_____

Parent / Guardian 1 Details: Name:_____
Email: _____Contact Number_____

Parent / Guardian 2 Details Name:_____
Email: _____Contact Number_____

How did you hear of / or were referred to Change for Life: _____

Has the child seen a Pediatrician? Yes/No
If yes, Pediatrician's details: _____

Has the child seen a Psychiatrist? Yes/No
If yes, Psychiatrist's details: _____

Has the child or family been referred to Child and Adolescent Mental Health Service (CAMHS)?
Yes/No
If yes, please provide details: _____

Funding Method:

- ☐ MHCP — If yes, referring Doctor's details: _____
- ☐ NDIS — If yes, NDIS participant number: _____
- ☐ Private Health Insurance
- ☐ DVA
- ☐ VOC
- ☐ TAC
- ☐ Privately paying none of the above: Please describe:

Clinical Diagnosis or concerns *(e.g. Dyslexia, Dysgraphia, Dyscalculia, Autism, ADHD;*
If yes, please provide any previous relevant reports from allied health professionals, medical professionals or schools.):

_____

Would you be okay to receive telehealth therapy? Yes/No

Has your child had previous counselling or psychology sessions? If yes please describe?

_____

Has seeing a psychologist been effective? how so?

_____

Risk Assessment

Has your child had a previous history of self-harm? Yes/No

If Yes, please describe: _____

Has your child had a previous history of suicidal thoughts? Yes/No

If Yes, please describe: _____

Has your child had a previous history of suicide attempts? Yes/No

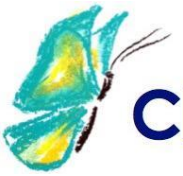
If Yes, please describe: _____

Does your child have any sensory behaviours that are of concern or are socially inappropriate? Yes/No

If Yes, please describe: _____

Currently, what do you or your child want to see a psychologist for:

☐ Anxiety	☐ Obsessive Compulsive Behaviour	☐ Eating problems / disorder
☐ Depression	☐ Adjustment, grief and loss	☐ Stress management
☐ Behaviour Intervention	☐ Social Skills	☐ Chronic or medical condition. If yes please describe: _____
☐ Autism Spectrum Disorder (ASD)	☐ Intellectual Disability	☐ Relationships
☐ School refusal	☐ Self-harm	
☐ Trauma (please describe):		
☐ Other:		



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Current level of communication
Will others be able to understand your child when he/she speaks?

Will your child be able to follow two-steps instructions?

Are they able to maintain a two-way conversation?

Please list your main concerns over the last 12 months? *(Extra information can be provided if needed)*

1. 4.
2. 5.
3. 6.

What school and grade is your child currently attending?

_____

Has your child been suspended or asked to leave school?

_____

Has the school voiced any concerns about your child's behaviour?

_____

_____

Has the school voiced any concerns about your child's progress academically?

_____

_____

Has the school voiced any concerns about your child's social interactions?

_____

_____

Has your child ever had trouble in school with any of the following? *(please check all that apply)*:

☐ Anxieties *(Please describe e.g. Separation Anxiety)*
☐ Obsessions
☐ Friends
☐ Cheating

- ☐ Stealing
- ☐ Fighting
- ☐ Setting fires
- ☐ Skipping school
- ☐ Running away
- ☐ Using drugs/alcohol
- ☐ Isolating from peers
- ☐ Talking too much in class
- ☐ Selling Drugs
- ☐ Not sitting still
- ☐ Inattention
- ☐ Bullying
- ☐ Being picked on
- ☐ Harming animals
- ☐ Task refusal
- ☐ Social difficulties
- ☐ Physical behaviours: hitting / kicking /spitting / biting / screaming / tantrum
- ☐ Being disruptive
- ☐ None of the above

What do you hope to achieve by seeing a psychologist:

By 1 month? _____

_____

By 6 months? _____

_____

By 12 months? _____

_____

Are you or your child involved in any current or have been (past) legal matters, or court proceedings and/or claims?: Yes / No

If yes, please describe:_____

Are you seeking psychological services in relation to family law matters? : Yes / No

Availability for sessions (*Sessions starting at 9 AM - 4 PM)***:**

- ☐ Monday AM / PM
- ☐ Tuesday AM / PM
- ☐ Wednesday AM / PM
- ☐ Thursday AM / PM
- ☐ Friday AM / PM

More about your child
What do you feel are your child's social and emotional strengths?

What has been successful?

Would you (parent) be interested in parent training/strategies for supporting your child and family interactions? : Yes / No

Would your child's siblings be interested in sibling support?: Yes/No

Please list activities, hobbies or toys that your child enjoys (Reinforcements).