School Age Form

Please fill in this questionnaire, if you are unsure about a question write "don't know" and we can discuss it further during the consultation.

FOR OFFICE USE

Pt No ______

Ex consent signed	Y	N
Inf consent signed	Y	N
GDPR Completed	Y	N
Reminder set up	Y	N
GP letter sent	Y	N

Ins Co __________

Ins Number ______

Name of child	
Address Post Code	
Telephone	Mobile
E-mail	
Age & DOB	Sex of child
Height	Weight

APPOINTMENT REMINDER SERVICE

A reminder will be sent to you **TWO DAYS** before any future appointment via text of email to the contact details above.

To ensure that more appointments are available to patients, **all missed appointments and late cancellations (less than 24 hours notice) will be charged at the full treatment rate.**

How would you like us to remind you? Please tick appropriate box:

- ☐ Text
- ☐ Email
- ☐ Please do not send me a reminder, I will remember

I hereby give consent for the aforementioned child to be examined; I will attend and understand that they may be partially undressed and a gown will be provided if required.

Parent/Guardian name ______

Parent/Guardian signature

How did you here about this clinic or Darren Barnes-Heath?

Please write the reasons for booking this appointment; typically this is the concerns parents have for their child but may include a desire to understand more about their difficulties or the hopes and expectations of tretament here. Write as much or little as you wish, the following pages will ask specific questions designed to give a broader picture.

Age & sex of any other siblings

Family set-up / who lives with the child?

Does anyone other than the birth Mother and Father have legal custody of the child? Yes / No

Did the Developmental Delay seem to progress gradually or was there any event that caused a set back?

When was the Development Delay Syndrome suspected?

Who noticed it first?

Has there been a diagnosis, if yes what and by who?

GP Name and Address

Any previous or ongoing interventions or appointments with paediatrican, CAMHS or psychotherapy, eductional psychologist, speech & language therapist, optician, nutritionist or others?

Have they had an eye test?

If any reports or educational plans etc. have been written about your child please list them and if possible include a paper copy or email a pdf/scan.

Teacher & School

SENCO or 1-2-1 support

This section asks about a wide range of factors that may influence brain development. It goes through these in a logical order for me to read through, please fill it out as best you can in whatever order you prefer. I don't expect you to know or recall all the questions. If you are unsure or have questions as to why I'm asking please contact me.

Family History

Is he or she adopted?

General health of mother? Good Moderate Struggling

Any significant or ongoing illnesses or medication?

Occupation of mother before & during pregnancy?

Age of mother at birth of child?

General health of father? Good Moderate Struggling

Any significant or ongoing illnesses or medication?

Occupation of father pre & during pregnancy?

Age of Father at birth of child?

Brief family history (parents/grandparents) - any known illnesses?

Are there any family history of learning difficulties or behavioural problems? YES NO

If yes, which family member and condition or suspected condition?

Any history of mental health problems?

Does mother, father or their family members have any allergies?

Pregnancy

Any previous miscarriages or stillbirths?

Were there difficulties conceiving?

Was IVF required?

Any trauma during pregnancy such as falls, car crashes, injuries, broken bones?

Any mental stress like divorce, bereavements or house moves?

Please tick any of these listed below that the mother had during the pregnancy.

- ☐ Bacterial infections
- ☐ Viral infections
- ☐ Excessive vomiting
- ☐ Excessive weight gain
- ☐ Diabetes or Gestational Diabetes
- ☐ Anaemia
- ☐ Other, please explain more
- ☐ Bleeding
- ☐ Hypertension
- ☐ Protein in the urine
- ☐ Convulsions
- ☐ Liver problems
- ☐ Kidney problems

Any medication (prescribed, recreation or over the counter) during pregnancy?

Were any nutritional supplements taken during the pregnancy?

Mother's diet, e.g. vegetarian, vegan, etc.?

Alcohol consumption during pregnancy?

Did the mother smoke during pregnancy? No Yes _______ / day

Did the father smoke during the ? No Yes _______ / day

Ultrasound scans during pregnancy (number & stage of pregnancy)

Birth		
Was the pregnancy full term?	Yes	No
How premature / late was the birth?		
Where was your baby born (hospital, home)?		
Drugs employed during the birth, e.g. gas and air/pethidine/epidural/other		
Was delivery natural or assisted with medical procedures?		
If assisted were forceps or ventouse used? Was it an elected or emergency cesarean?		
Any foetal distress, (was baby's herat rate too high or low, oxygen levels low or other concerns)		
APGAR score if known, should be in red baby record book		
Birth weight	Length	
Was placenta normal size and weight?		
Details about the birth, how long it took, when waters broke, which way round baby was etc.		
How do you feel about the birth process, (not your child)? This can range from wonderful to extreamly traumatic and disempowering.		
Please outline what happened after the birth, did baby cry then try to feed or require resucitation, cleaning up, other specialist care?		

Development: Feeding & Digestion
Did your baby have difficulty breastfeeding or were they bottle fed from birth?
When and what formula used?
When were solids introduced and what was first solid?
Was he/she prone to colic? If yes please explain
Was he/she prone to reflux or vomiting? If yes please explain
Any bowel problems as a baby?
When was he/she dry by day? Was potty training required?
When was he/she dry by night?
Have there been an accidents or regressions since?
Once potty trained was there or is there any soiling?
Describe his/ her bowel habit: Frequency, consistency etc! Does he/she seem to experience any stomach, bowel or adbominal pain?
Are there any foods your child will crave or consistently request?
Have you noticed any type of food or drink which affect digestion, stools or cause pain?

Development: Movement

When was your baby able to lift their head up?

Could you baby turn their head evenly to each side?

Was there any uneveness or flattening of the back of their head?

Did your baby roll? Could they do it in both directions?

When did your baby sit unaided, able to sustain the position?

If they toppled while sitting could they stop themselves falling with their arm(s)?

Did your baby crawl? Yes No

If Yes, at what age?

Was there anything unusal about their crawling; bottom shuffling, not using a limb?

When did he/she walk?

Once walking was he / she clumsy, awkward when running?

When did he / she learn to:

- Ride a bike
- Dress themselves
- Tie shoelaces

Is your child right or left handed? Is your child right or left footed?

When do you think their handedness/ dominence became apparent?

Describe his/ her Sporting Ability

Are there physical activities he/she particularly enjoys or will avoid?

Development: Academic

When did your child start babbling?

Using single words?

Saying two words together?

Talking in Mini sentences?

How was their pronounciation, did they speak clearly?

Did they make up words or consistently say some incorrectly?

When did they count to ten?

If they went to nursery or preschool were any concerns raised about their speech and language?

These questions ask about their current acadeamic performance

Reading ability & Reading age

What genre do they tend to or like to read if any?

Hand writing: neat / messy / slow etc. Can they express thoughts onto paper?

Mathmatics?

Which are their favourite / least disliked subjects?

Which subjects do they find hardest?

How is their concentration?

How is their short term memory?

Have they had an extra support with any subjects?

Development : Emotions & Behaviour
When he/she was a baby how did they sleep?
Did you feel connected to your baby and was there eye contact?
How did they cope when they started nursery or school?
Any behavioural problems at school, nursey OR at home
Is your child hyperactive? Is this at school and at home?
Any rituals or obsessions, tics or involuntary movements, hand flapping or spinning?
Describe his/ her social interactions?
Does he/she exhibit empathy, can they understand other's point of view?
Is he/ she anxious? What will cause anxieties?
Describe his/ her sleep pattern including how he /she gets to sleep now
Do any foods or drinks trigger a change in behaviour?
Hobbies, favourite past time
Hours watching TV/ screens, games & phones per day?

Medical History

Please tick any of these listed below that your child has had

- ☐ Operations
- ☐ Illnesses other than regular ones
- ☐ Head Injuries
- ☐ Headaches
- ☐ Broken bones
- ☐ Dizziness or feel faint
- ☐ Diabetes or Gestational Diabetes
- ☐ Asthma, eczema or any allergies
- ☐ Recurrent Infections
- ☐ Noise in the ear(s)
- ☐ Double or blurred vision
- ☐ Road Traffic Accidents
- ☐ Convulsions or epilepsy
- ☐ Congenital conditions

Please add details:

Has your child had an eye test, do they require glasses or contacts?

Have you noticed that your child has an increased or decreased sense of smell

Have they had dental work or braces

Does your child suffer from any aches or pains including growing pains?

Has your child been prescribed any medication?

How many times has your child taken anti-biotics?

Is your child taking any other remedies?

Anything else you would like to mention?

Food and Drink Diary

Please list any dietary supplements your child is taking
What benefit have you seen?
Please complete the form below, detailing your child's 'typical' weekly diet, to include all food and drinks. Try to mention all snacks, sweets and drinks including water. It is helpful if you can give some indication fo the amount e.g. number of slices/pieces, large/ small and type e.g. wholemeal, fresh, skimmed etc. thank you.
DAY ____________________________
BREAKFAST
Food
Drink
SNACKS
Food
Drink
LUNCH
Food
Drink
SNACKS
Food
Drink
EVENING MEAL
Food
Drink
SNACKS
Food
Drink
Where does your child have Breakfast Lunch Evening Meal

DAY ________________________

BREAKFAST
Food
Drink
SNACKS
Food
Drink
LUNCH
Food
Drink
SNACKS
Food
Drink
EVENING MEAL
Food
Drink
SNACKS
Food
Drink

DAY ________________________

BREAKFAST
Food
Drink
SNACKS
Food
Drink
LUNCH
Food
Drink
SNACKS
Food
Drink
EVENING MEAL
Food
Drink
SNACKS
Food
Drink

DAY ________________________
BREAKFAST
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Drink
SNACKS
Food
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LUNCH
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SNACKS
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EVENING MEAL
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