

# Change for Life

## Child Enquiry Form (Preschool)

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

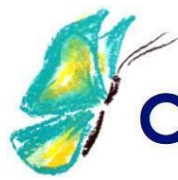
If yes, please provide details: \_\_\_\_\_

### Funding Method:

- |   |  |
|---|--|
| <input type="checkbox"/> MHCP   | <input type="checkbox"/> If yes, referring Doctor's details: _____ |
| <input type="checkbox"/> NDIS   | <input type="checkbox"/> If yes, NDIS participant number: _____    |
| <input type="checkbox"/> Private Health Insurance                                   | <input type="checkbox"/> DVA                                       |
| <input type="checkbox"/> VOC  | <input type="checkbox"/> TAC                                       |
| <input type="checkbox"/> Privately paying none of the above: Please describe: _____ |  |

Clinical Diagnosis or concerns (if any): \_\_\_\_\_

### Risk Assessment



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Has your child had a previous history of self-harm? 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: \_\_\_\_\_

**Would you be okay to receive telehealth therapy?** \_\_\_\_\_

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

\_\_\_\_\_

**If yes, has seeing a psychologist been effective? How so?**

\_\_\_\_\_

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

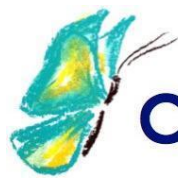
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Obsessive Compulsive Behaviour	<input type="checkbox"/> Eating problems / disorder
<input type="checkbox"/> Depression	<input type="checkbox"/> Adjustment, grief and loss	<input type="checkbox"/> Stress management
<input type="checkbox"/> Behaviour Intervention	<input type="checkbox"/> Social Skills	<input type="checkbox"/> Chronic or medical condition. If yes please describe: _____
<input type="checkbox"/> Early Intervention	<input type="checkbox"/> Autism Spectrum Disorder (ASD)	<input type="checkbox"/> Intellectual Disability
<input type="checkbox"/> Trauma (please describe):		
<input type="checkbox"/> Other:		

## **Current level of communication**

Is your child able to express him/herself in short simple sentences (4-5 words)?

Will others be able to understand your child when he/she speaks?

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



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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.	2.
3.	4.
5.	6.

**Is your child currently attending daycare or Kindergarten?**

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**Has daycare/kindergarten voiced any concerns about i) how your child's behaviour, ii) progress in learning or iii) socially?**

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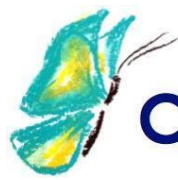
**Has your child been asked to leave daycare or kindergarten?**

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

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Anxieties (Please describe e.g. Separation Anxiety)                             | <input type="checkbox"/> Obsessions      | <input type="checkbox"/> Friends             | <input type="checkbox"/> Not sitting still |
| <input type="checkbox"/> Stealing  | <input type="checkbox"/> Fighting        | <input type="checkbox"/> Setting fires       | <input type="checkbox"/> Being picked on   |
| <input type="checkbox"/> Running away  | <input type="checkbox"/> Harming animals | <input type="checkbox"/> Social difficulties | <input type="checkbox"/> Being disruptive  |
| <input type="checkbox"/> Inattention   | <input type="checkbox"/> Bullying        | <input type="checkbox"/> Task refusal        | <input type="checkbox"/>                   |
| <input type="checkbox"/> Physical behaviours: hitting / kicking /spitting / biting / screaming / tantrum | <input type="checkbox"/> Other:          | <input type="checkbox"/>                     | <input type="checkbox"/> None of the above |

**What goals do you hope to achieve by seeing a psychologist:**



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**By 1 month?**

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**By 6 months?**

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**By 12 months?**

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

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

**Availability for sessions** (Sessions starting at 9 AM - 2 PM):

- |                                    |                                  |                                   |                                  |
|------------------------------------|----------------------------------|-----------------------------------|----------------------------------|
| <input type="checkbox"/> Monday    | <input type="checkbox"/> AM / PM | <input type="checkbox"/> Tuesday  | <input type="checkbox"/> AM / PM |
| <input type="checkbox"/> Wednesday | <input type="checkbox"/> AM / PM | <input type="checkbox"/> Thursday | <input type="checkbox"/> AM / PM |
| <input type="checkbox"/> Friday    | <input type="checkbox"/> AM / PM |                                   |                                  |

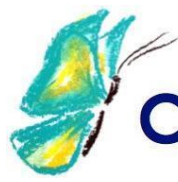
## **More about your child and parenting**

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

What has been successful in helping them cope with emotional distress?

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



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