Danny's Place
Be your best

Health Questionnaire

Dear Parent / Guardian, to help us to do an accurate assessment of your child's health, please complete this health questionnaire and bring it to your initial paediatrician appointment.

For Internal Use Only

First Name:_____ Surname:_____Date of Birth:_____

Initial Visit:_____ Referring Doctor:_____ GP:_____

General Overview

Who is completing this questionnaire? ☐ Mother ☐ Father ☐ Guardian ☐ Other _____

Are any other specialists involved in your child's care?

Paediatrician: _____

Psychologist:_____

Specialists: eg. ENT:_____

Allied Health eg. Physio / OT:_____

Do you consent to us contacting or sharing information with them about your child's care? ☐ Yes ☐ No

Does your child have any known medical diagnosis / conditions? ☐ No ☐ Yes If yes, please list

_____

_____

_____

Does your child take any medications? ☐ No ☐ Yes If yes, please list

_____

_____

_____

Does your child have any allergies? ☐ No ☐ Yes If yes, please list

_____

_____

Are your child's vaccinations up to date? ☐ No ☐ Yes

Hospitalisations and Surgery

Has your child been admitted to hospital previously? ☐ No ☐ Yes, please list: _____

_____

_____

_____

Has your child had any surgery in the past? ☐ No ☐ Yes, please list:

_____

_____

_____

Danny's Place
Be your best

Health Questionnaire

Birth and developmental history

If known please provide some information about your child's birth history:

Birth weight (kg): _____

Gestation: ☐ Term ☐ Preterm (< 37 weeks gestation) ☐ Gestational diabetes: ☐ Yes ☐ No

Was your child breastfed? ☐ No ☐ Yes If yes, how many months of breastfeeding? _____

Did your child receive antibiotics in the newborn period? ☐ No ☐ Yes ☐ Unknown

Reason for antibiotics, if known: _____

Dietary, Activity, Sleep history

Dietary pattern related:

Does your child eat breakfast?	everyday / most days / rarely / never
Does your child eat fruits / vegetables ?	everyday / most days / rarely / never
Does your child drink sweetened/energy/soft drinks?	everyday / most days / rarely / never
Does your child have extra helpings at dinner?	everyday / most days / rarely / never
Does your child snack after dinner?	everyday / most days / rarely / never
Does your family eat dinner together?	everyday / most days / rarely / never
How often does your child eat out in a week?	_____ days/ week

Activity pattern related:

How many hours a day does your child use combined screen time (computer/video games/TV/mobile phone):

On school days:_____ hours, On weekends:_____ hours

Physical activities enjoyed: _____

Other leisure activities enjoyed: _____

Does your child have any limitations to exercise:

☐ None ☐ Breathlessness ☐ Leg/joint pain ☐ Environmental ☐ Other: _____

Sleep pattern related:

What is your child's usual bedtime and waking time on school days?

Bedtime _____am/ pm Waking time _____ am / pm

What is your child's usual bedtime and waking time on weekends/holidays?

Bedtime _____am/ pm Waking time _____ am / pm

Social History

Who are the other family members living with your child?

☐ Child's parents ☐ Both ☐ One ☐ Step parents ☐ Shared Care _____

☐ Child's siblings, If yes, how many _____

Other relatives/friends, If yes, how many others? _____

Danny's Place
Be your best

Health Questionnaire

Current Medical History

Does your child currently have any of these symptoms / problems?

	Yes	No	Details
Fatigue/ low energy levels	☐	☐	_____
Mental health / Behavioural concerns	☐	☐	_____
Headaches	☐	☐	_____
Vision problems	☐	☐	_____
Shortness of breath	☐	☐	_____
Wheeze	☐	☐	_____
Chest pain	☐	☐	_____
Palpitations	☐	☐	_____
Nausea/ vomiting	☐	☐	_____
Abdominal pain	☐	☐	_____
Diarrhoea	☐	☐	_____
Constipation	☐	☐	_____
Urinary problems	☐	☐	_____
Joint pains	☐	☐	_____
Muscle weakness	☐	☐	_____
Hair loss	☐	☐	_____
Skinfold infections	☐	☐	_____
Striae (stretch marks)	☐	☐	_____
Acne	☐	☐	_____
Excess facial hair (in girls)	☐	☐	_____

At what age did you first notice signs of puberty in your child? _____ years

For girls, at what did your child have her first period? _____years

If menstruating, are your child's periods regular? ☐ No ☐ Yes Comments:_____

Weight Management History

What are your main concerns about your child's excess weight?

_____

_____

_____

_____

_____

How long have you had concerns? _____

What previous methods have you tried in the past to address your child's excess weight?

_____

_____

What possible things do you feel are contributing to your child's excess weight?

_____

_____

_____

Danny's Place
Be your best

Health Questionnaire

Schooling History

Schooling related:

Does your child currently attend school? ☐ Yes ☐ No Are they home-schooled? ☐ Yes ☐ No

Name of school: _____ Year level: _____ Days attended per week: _____

School performance and grades: ☐ Above average ☐ Average ☐ Below average ☐ Struggling

Does your child have any identified learning difficulties: ☐ Yes ☐ No if yes, please specify difficulty

_____

PE/sport skills and participation: ☐ Above average ☐ Average ☐ Below average ☐ Struggling

Social skills: ☐ Above average ☐ Average ☐ Below average ☐ Struggling

Any other comments:

_____

_____

Family History

Please answer yes if any of your child's family members have any below conditions? If yes, which family member/s?

Overweight/Obesity _____

Weight-loss surgery _____

High blood pressure _____

Stroke_____ _____

Heart disease _____

Abnormal lipids/ cholesterol _____

Type 2 diabetes_____

Snoring/ sleep apnoea_____

Blood disorders (clotting)_____

Cancer_____

Liver or gall bladder disease_____

Mental health concerns_____

Tobacco use _____

Other relevant family history or comments:

_____

_____

_____

Thank you for taking the time to complete this form