NEW PATIENT HEALTH QUESTIONNAIRE (Child Under 18)

UNSWORTH GROUP

The Child's Contact Details

Title		Date of Birth	
Surname		Forename(s)	
Previous Surnames		Email	
Home Address	House Name / Flat No		
	No and Street		
	Village		
	Town		
	Postcode		
Home Tel No			

Other Details

School / Nursery Attended:	
Name and contact details of current Health Visitor or School Nurse *(if known)*	

Alternative / Emergency Contact Details

Details of The Child's Emergency Contact	Title		Forename	
	Surname		Date of Birth	
	Address			
	Home Tel No		Mobile No	
	Work Tel No		Relationship to you	
Is this person the child's next of kin?				☐ Yes ☐ No
Is this person the child's Emergency Contact?				☐ Yes ☐ No

Ethnicity

White	☐ British	☐ Irish	☐ Other	If other, please specify	
Black or Black British	☐ Caribbean	☐ African	☐ Other	If other, please specify	
Asian or Asian British	☐ Indian	☐ Pakistani	☐ Bangladeshi	☐ Other	If other, please specify
Mixed	☐ White and Black Caribbean		☐ White and Black African		
	☐ White and Asian		☐ Other, please specify		
Chinese	☐ Chinese		Any other Background, please write below		
Preferred Spoken Language					
Does the child require an interpreter?	☐ Yes ☐ No				
Does the child require an interpreter for British Sign Language?	☐ Yes ☐ No				

Medical Information

Has the child suffered from any of the following:-	
Any significant illness requiring treatment at hospital?	☐ Yes ☐ No If yes, please give details
Had any operations?	☐ Yes ☐ No If yes, please give details
Difficulties with Hearing?	☐ Yes ☐ No If yes, please give details
Difficulties with Speech?	☐ Yes ☐ No If yes, please give details
Difficulties with Vision?	☐ Yes ☐ No If yes, please give details

Developmental issues?	☐ Yes ☐ No If yes, please give details
Does the child suffer with Asthma?	☐ Yes ☐ No
Does the child suffer from Diabetes?	☐ Yes ☐ No
Has the child ever suffered from faints, fits or seizures?	☐ Yes ☐ No
Does the child suffer from a mental health illness?	☐ Yes ☐ No
Other, please specify	

Please list any medicines that the child is currently taking and the amount:-
Is the child registered disabled? (If yes, please give details) ☐ Yes ☐ No
Is the child allergic to any medicines and if so, which? ☐ Yes ☐ No
Is the child allergic to anything other than medicines, such as certain foods, metals or latex? (Please give details) ☐ Yes ☐ No

Immunisations

Is the child up to date with their immunisation schedule? ☐ Yes ☐ No ☐ Not Sure

Family History

Has the child's parent(s) or sibling(s) ever suffered from the following:-					
Epilepsy	☐ Yes	☐ No	Blindness / Glaucoma	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Heart Attack	☐ Yes	☐ No	Stroke / TIA	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Asthma	☐ Yes	☐ No

Eczema	☐ Yes ☐ No	COPD	☐ Yes ☐ No
Angina	☐ Yes ☐ No	Hayfever	☐ Yes ☐ No
Thyroid Disease	☐ Yes ☐ No	Raised Cholesterol	☐ Yes ☐ No
Other, please specify			

Other

Does the child, or anyone within your household currently have a Social Worker?	☐ Yes ☐ No	Name of Social Worker: Telephone Contact:	
Is the child living with someone who is not their parent or close family relative?	☐ Yes ☐ No	If so, who?	

Do you have parental responsibility for the child?	☐ Yes ☐ No
Is the child you are registering "looked after" by the local authority or subject of a Child Protection Plan?	☐Yes ☐ No
Is your child a carer for you or someone else?	☐ Yes ☐ No If, yes, for whom?

Is there any other information that you feel is important for us to know, to ensure that we can look after your child properly?

………

Name of Person Completing This Form	
Relationship to the Child	
Signature	
Date Form Completed	