Child name:	Place label here
☐ Male ☐ Female DOB:	

Welcome to Karitane Early Parenting Centre, child and family health consultation online booking service.

- To help us provide the best service to you, we have a few questions for you to answer relating to you and your child's health and wellbeing.
- The information you provide is voluntary and we will keep all records confidential, unless there are safety risks identified for you or your baby.
- Please arrive approximately 10 minutes prior to your appointment time so we can review your details with you and record any changes prior to seeing the Child and Family Health Nurse.
- Please note: there is a parent room/change facility available next door to our centre should you require it.

We look forward to meeting you at your appointment.

Title		Family Name		First Name	
Sex		DOB		Street Address	

Suburb		State		Postcode		Country	
Marital Status		Country of Birth					

Aboriginality: ☐ Aboriginal ☐ Torres Strait Islander ☐ Both ☐ Declined ☐ Neither

Preferred Language		Interpreter Required	Yes | No	Usual GP Local Doctor	
Medicare No		Expiry:		Reference no.	
Health Fund	Yes | No			Member No	

How did you hear about this service?

☐ Karitane Website ☐ Social Media ☐ Word of Mouth ☐ Dr/Community Health Staff ☐ Other

Question	Response
1. What is the main issue/problem you would like discuss at your consultation?	
Comment:	
2. How long have you and your child been experiencing the issue you are seeking help with?	☐ more than a month ☐ 2 weeks ☐ Less than 2 weeks
Comment:	
3. Have you tried anything to help resolve the current issue/problem	☐ yes ☐ no
Comment:	
4. Do you have practical support with your baby/child?	☐ yes ☐ no
Comment:	
5. Do you have someone you are able to talk to about your feelings or worries?	☐ yes ☐ no
Comment:	

Question	Response
6. Have you had any major stressors, changes or losses recently (ie in the last 12 months) such as, financial problems, someone close to you dying, or any other serious worries?	☐ yes ☐ no
Comment:	
7. Generally, do you consider yourself a confident person?	☐ yes ☐ no
Comment:	
8. Does it worry you a lot if things get messy or out of place? (Would you call yourself a perfectionist?)	☐ yes ☐ no
Comment:	
9. Have you ever experienced, anxiety/ depression or other mental health concerns or problems which has lasted more than a couple of weeks?	☐ yes ☐ no
Comment:	
10. If yes, did it or does it, seriously affect your work or relationships with family/friends/work?	☐ yes ☐ no
Comment:	
11. Are you currently receiving, or have you in the past received, treatment for any emotional or mental health problems? If yes what was it?	☐ yes ☐ no
Comment:	
12. How would you describe your relationship with your partner?	
Comment:	
13. Do you and partner parent the same?	☐ yes ☐ no
Comment:	
14. Are there any other issues or worries you would like to mention?	☐ yes ☐ no
Comment:	
15. Does your child have any medical conditions/disability or do you have any concerns about your child's health? (E.G. allergies, heart problems, reflux, asthma, urinary problems, behaviour problems)	☐ yes ☐ no
Comment:	
16. Do you /partner have any medical conditions/disability or do you have any health concerns? (E.G. allergies, heart problems, reflux, asthma, urinary problems, birth trauma, difficult pregnancy, drug problems etc)	☐ yes ☐ no
Comment:	
17. Do you or your partner smoke?	☐ yes ☐ no
Comment:	