**New Patient Questionnaire for Child under 18**

Name ……………………………………………………………………………… Date of Birth………………………………

Mother’s Name ……………………………………………………….Telephone number……………………………………………

Address Details (if different from Childs) ……………………………………………………………………………………………

Father’s Name ………………………………………………………….Telephone number…………………………………………..

Address Details (if different from child’s)……………………………………………………………………………………………

**Who has parental responsibility?** (Please circle one or both if applicable) Mother Father

Someone else (please state name and relationship to child)…………………………………………………………………

**Next of Kin (Emergency Contact- if different from above)**

Name: ……………………………………………………………..

Address: ……………………………………………………………………………………………………………………………………………………….

Telephone (Home): ……………………Telephone (Work) :…………………….Telephone (Mobile):………………………………

**OTHER INFORMATION**

If your child is under 1 year of age: were they premature? Yes / No

Is your child home-schooled? Yes / No If No, which school do they attend?........................................

Name of previous schools (if any): ……………………………………………………………………………………………………………………

Has your child ever been suspended (received a fixed-term exclusion) or permanently excluded from school? Yes / No

Name of Health Visitor/School Nurse (if known) …………………………………………………………………………………….......

Has the child ever been the subject of a Child Protection Plan? Yes / No. If yes, when?...............................

Has your child ever been a “Looked After” child (i.e. in Foster Care or in a Children’s Home)? Yes / No

**HOUSING:** What type of house does the child live in? (Please circle) Privately owned Council owned

House or flat (If flat which floor?) …………………………

Are there any housing problems? e.g. overcrowding, damp…………………………………………………………..

Please list all the people (children & adults) that share the house with the child and their relationship to them

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| --- | --- | --- | --- |
| **NAME OF PERSON** | **ADULT or CHILD (Please give age if under 18)** | **RELATIONSHIP TO CHILD** | **ARE THEY REGISTERED AT THIS PRACTICE?** |
|  |  | **MOTHER** | YES / NO |
|  |  | **FATHER** | YES / NO |
|  |  | **BROTHER / SISTER** | YES / NO |
|  |  |  | YES / NO |
|  |  |  | YES / NO |