4 Year Old Healthy Kids Check

Parent / Carer Questionnaire

What is the aim of a Healthy Kids Check and what does it include?

The aim of the Healthy Kids Check is to improve the health and well-being of Australian children and promote early detection of lifestyle risk factors, delayed development and illness. It also provides the opportunity to discuss with your family doctor or practice nurse guidance on healthy lifestyles and early intervention strategies for your child.

A Healthy Kids Check will include an assessment of your child's height and weight, an assessment of their eyesight, hearing and oral health and discussion about their toilet habits and known or suspected allergies.

You are requested to complete this questionnaire and then give it to your practice nurse. Please be as honest as possible, your answers will be critical in determining if there are any areas of your child's development that may require some additional assistance.

Child's Full Name: ________________________________ Preferred Name: ___________________________

Date of Birth: _____________________ Male / Female

Is your child Aboriginal or Torres Strait Islander? Yes No

Allergies

Does your child have any allergies Yes No

If yes please describe: ____

Medical History

Has your child got any ongoing health problems or conditions? (E.g. asthma, eczema) Yes No

If yes, please give details: ____

Has your child ever had any surgery? Yes No

If yes, please give details: ____

Social History

Are there any brothers or sisters living with your child? Yes No

If yes, please provide details of siblings: ____

Are there any care arrangements in place? Yes No

If yes, please provide relevant details: ____

Vision

Are you concerned about your child's vision? Yes No

If 'yes' please describe your concerns: ____

Has medical care been sought for your child's eyes / vision? Yes No

If 'yes' please describe: ____

Is there any family history concerning vision? Yes No

If 'yes' please describe: ____

Hearing

Do you have any concerns about your child's hearing? Yes No

If 'Yes' please describe: ____

Has your child had any of the following?

Repeated ear infections discharging ears hearing loss ear operations

Is there a family history of childhood deafness or hearing impairment? Yes No

If 'Yes' please describe: ____

Oral health

Do you consider your child to have healthy teeth and gums? Yes No

Does your child have a tooth brushing routine? Yes No

Has your child been seen by a dentist? Yes No

Toilet habits

Does your child toilet independently? Yes Mostly No

Does your child wet the bed? Yes Sometimes No

Eating Habits

Do you consider your child to have a: large appetite healthy appetite small appetite?

Physical Activity

Do you consider your child to be: overactive normally active underactive?

Speech / language

Do you have concerns about your child's speech or language development? Yes No

Does your child ask complex questions using words like; "because"? Yes No

Is your child understood when speaking to other adults? Yes No

Do you think your child talks like other children the same age? Yes No

Can your child use two or more personal pronouns (I, you, he, she etc?) Yes No

Can your child hold conversations? Yes No

Can your child understand human feelings? (eg. Cold, tired, hungry) Yes No

Is your child able to quietly listen to stories? Yes No

Fine and Gross Motor Skills

Do you have concerns about your child's fine or gross motor skills? Yes No

Can they catch a large ball? Yes No

Is your child running, jumping, hopping and climbing stairs? Yes No

Is your child able to pick up small objects? Yes No

Can your child do up buttons, put on socks and shoes? Yes No

Can your child fully undress? Yes No

Behaviour and mood

Do you have concerns about your child's general behaviour or mood? Yes No

Socially

Do you have concerns about your child's social skills development? Yes No

Does your child know their full name and address and age? Yes No

Can your child play games in groups with simple rules? Yes No

Is your child able to mix with other children? (Share, take turns) Yes No

Is your child developing the ability to separate from the main carer? Yes No

Intellectual

Do you have concerns about your child's intellectual ability? Yes No

Create play with stories with different rules? Yes No

Compare objects as higher or longer? Yes No

Count to 5? Yes No

Count objects? Yes No

Can your child match or name 5-6 colours? Yes No

I have completed this questionnaire to the best of my knowledge.

Parent / Carer Name: ____

Signature: ____

Date: ____________________________________