MEDICAL APPOINTMENT TEMPLATE

CHILD OR YOUNG PERSON'S DETAILS

Surname:	Address:
First Name:	
Preferred Name:	
Date of Birth:	
Gender (tick box) Male ☐ Female ☐ Prefer not to say ☐	Postcode:
	Telephone No:

PARENT OR CARER DETAILS

MR/MRS/MS/MISS	Surname :	Address:
First Name:		
Preferred Name:		
Date of Birth:		
Email Address:		Postcode:
Home Telephone No:	Mobile Telephone No:	

EDUCATION DETAILS

Name of current School/Nursery/Education setting. If Home Education, Please state this:	
Address:	
Length of time in current School/Nursery/Education setting:	Home Telephone No:
Has their current School/Nursery/Education setting/Childcare raised any concerns with you about your Child or Young Person? If YES, Please list the concerns they have raised:	

MEDICAL HISTORY

What other Health Professiosnals work with yourChild or Young Person currently?

Does your Child or Young Person have any diagnosed medical conditions?

Does your Child or Young Person take any prescribed medication? If YES, Please list name, dose and frequency that they take them.

Name	Dose	Frequency

Have they spent any time in Hospital since birth?

Does your Child or Young Person have any allergies? YES ☐ NO ☐ UNSURE ☐

CURRENT CONCERNS

What are your current concerns about your Child or Young Person's development?

Have they reached all of the developmental milestones for their age? If not, Please list those they have NOT met, if known.

CURRENT CONCERNS Continued...

If they have siblings, did they experience delays in reaching any of their developmental milestones?

What are your current concerns about your Child or Young Person's behaviour? How long have the behaviour concerns been happening?

Have they experienced stress, trauma or bullying before or during the time that you have become concerned about their development or behaviour? (This could include moving home, a death in teh family or a pet, changing School, etc).

Did they have an accident or injury before or during the time that you have become concerned about their development or behaviour?

GENERAL HEALTH

How much does your Child or Young Person sleep at night?

Do they experience and slepp difficulties? (Falling asleep, staying asleep, nightmares, night terrors, etc).

Would you describe their general health as good? (Do they get ill more frequently than others, etc).

Toileting - Do they experience any difficulties with toileting? (Frequent diarrhoea or constipation, incontinence, inability to tell when they need to use the toilet, frequeant trips to the bathroom, etc).

How would you describe your Child or Young Person's eating habits? (Do they eat a range of different foods? Do they eat regular meals everyday?).