Kinderarztpraxis

Dr. Junge & Goecke

Parent Questionnaire — Preventive Check-Up J1

Adolescent's name	
Date of birth	

Dear parents, we kindly ask you to complete this questionnaire in advance and send it to us by email, or bring it to the J1 check-up. This helps us better assess your child's development. Thank you for your support!

General Questions

1. Which parent(s) have legal custody of the child? ☐ Mother ☐ Father ☐ _____
2. Is one parent raising the child alone? ◯ Yes ◯ No
3. Are the parents separated? ◯ Yes ◯ No
4. Has one parent passed away? ◯ Yes ◯ No
5. Does your child have siblings? ◯ Yes ◯ No
   If yes, how many? _____
6. Does your child have their own room? ◯ Yes ◯ No
7. Are there frequent conflicts at home? ◯ Yes ◯ No
   If yes, what kind? _____
8. How would you rate the level of trust between you and your child? Please rate on a scale of 1 (very high trust) to 6 (very little trust) _____
9. Do you smoke? ◯ Yes ◯ No

Health

10. Did your child have any developmental problems? If so, at what stage? ◯ Toddler years ◯ Pre-school years ◯ School years
    If yes, what kind? _____
11. Are there any known illnesses or disabilities? ◯ Child ◯ Parents ◯ Siblings ◯ Grandparents
    If yes, what? _____
12. Has your child ever had surgery? ◯ Yes ◯ No
    If yes, what? _____
13. Does your child take medication regularly? ◯ Yes ◯ No
    If yes, which? _____
14. Has your child received all required vaccinations? Please bring the vaccination record! ◯ Yes ◯ No ◯ Not known

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Behavioural Concerns

15. Are there any concerns about speech or language? ◯ Yes ◯ No
    If yes, what kind? _____
16. Are there any concerns about emotional development? ◯ Yes ◯ No
    If yes, what kind? _____
17. Are there any difficulties in social interactions? ◯ Yes ◯ No
    If yes, what kind? _____
18. Are there any difficulties at school? ◯ Yes ◯ No
    If yes, what kind? _____
19. Are there any learning difficulties or problems concentrating? ◯ Yes ◯ No
    If yes, what kind? _____
20. Are there any sleep problems? ◯ Yes ◯ No
    If yes, what kind? _____
21. Are there any eating or weight issues? ◯ Yes ◯ No
    If yes, what kind? _____
22. Is your child showing signs of anxiety? ◯ Yes ◯ No
    If yes, what kind? _____
23. Are there any vision or hearing problems? ◯ Yes ◯ No
    If yes, what kind? _____
24. Are there any issues with alcohol, cigarettes, or drugs? ◯ Yes ◯ No
    If yes, what kind? _____

General Development

25. Does your child have any special talents or interests? ◯ Yes ◯ No
    If yes, what? _____
26. Does your child have hobbies? ◯ Yes ◯ No
    If yes, what? _____
27. Is your child physically active? ◯ Yes ◯ No
    If yes, which sports? _____
28. Does your child have friends their own age? ◯ Yes ◯ No
29. How satisfied are you with your child's overall development? Please rate on a scale of 1 (very satisfied) to 6 (not satisfied at all) _____
30. How satisfied are you with your child's progress at school? Please rate on a scale of 1 (very satisfied) to 6 (not satisfied at all) _____