



Please list any medications your child takes regularly, including non-prescription medications and explain what it is for.


Hearing	Does your child have any hearing or vision problems? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	If yes, is this a new issue?	
Dental	Does your child see a dentist regularly? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	If yes - Any procedures in past 12 months?	If no – do you have any concerns about your child's teeth?

School Attendance		
Does your child currently attend school or other educational institution?		
If Yes, please select one <input type="checkbox"/> 3yr old kindergarten <input type="checkbox"/> 4yr old kindergarten <input type="checkbox"/> School <input type="checkbox"/> TAFE <input type="checkbox"/> University <input type="checkbox"/> Other	If no, please select one <input type="checkbox"/> Too young <input type="checkbox"/> Employed Job Title _____ Number of hours worked (F/T, P/T, casual, home duties etc) <input type="checkbox"/> Other	Compared to others in the same class/ year level, how is your child managing with school/ work? <input type="checkbox"/> Well above average <input type="checkbox"/> Above average <input type="checkbox"/> Average <input type="checkbox"/> Below average <input type="checkbox"/> Well below average

Is your child currently experiencing any difficulty with: ( please tick)			
Ongoing absences from school <input type="checkbox"/>	Catching up on missed schoolwork <input type="checkbox"/>	Concentration <input type="checkbox"/>	Comprehension <input type="checkbox"/>
Memory <input type="checkbox"/>	Handwriting/ fine motor coordination <input type="checkbox"/>	Hearing or vision <input type="checkbox"/>	Fatigue <input type="checkbox"/>

Does your child receive any additional supports at school (please select any that apply)					
Integration aide <input type="checkbox"/>	Reading recovery <input type="checkbox"/>	Modified curriculum <input type="checkbox"/>	Classroom or Playground assistance <input type="checkbox"/>	Physiotherapy <input type="checkbox"/>	Occupational therapy <input type="checkbox"/>
Speech therapy <input type="checkbox"/>	Extra tutoring <input type="checkbox"/>	Ronald McDonald Learning Program <input type="checkbox"/>	Other (specify)		

How often does your child miss school?				
Never <input type="checkbox"/>	Rarely <input type="checkbox"/>	Sometimes <input type="checkbox"/>	Quite Often <input type="checkbox"/>	Very Often <input type="checkbox"/>

What are the causes for school absence (select any that apply)					
Minor illnesses <input type="checkbox"/>	Major health concerns related to cancer and therapy <input type="checkbox"/>	Non-specific illnesses with vague symptoms (e.g. headache, upset tummy) <input type="checkbox"/>	Attending medical appointments <input type="checkbox"/>	Child reluctance or refusal <input type="checkbox"/>	Anxiety <input type="checkbox"/>

If employed, how much time does your child miss from their employment?  
If so, why?

Has your child ever undergone neuropsychological screening or testing? i.e - have they had an IQ test or had a test of their memory or academic abilities? If yes, where did testing take place and in what year?	RCH	MMC	School	Private	Other
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Have your child's school raised any concerns/ worries about your child?'  Yes  No

Do you have any concerns about your child's educational or employment opportunities (either current or future) that you would like to discuss when you come to LTF clinic?

Does your child participate in physical activity? (choose any that apply)	School curriculum – physical education <input type="checkbox"/>	Extra-curricular team sports <input type="checkbox"/>	Individual sports <input type="checkbox"/>	Kinder-gym <input type="checkbox"/>
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How does this level of physical activity compare to your child's participation prior to cancer treatment?	Much more <input type="checkbox"/>	More <input type="checkbox"/>	The same <input type="checkbox"/>	Less <input type="checkbox"/>	Much less <input type="checkbox"/>
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Does your child have other hobbies/ activities they enjoy?

Compared with other children of the same age, how does your child manage fine motor tasks like handwriting, using computers, picking up small objects, using scissors etc	Better <input type="checkbox"/>	Same <input type="checkbox"/>	Not as well <input type="checkbox"/>
Compared with other children of the same age, how does your child cope with reading?	Better <input type="checkbox"/>	Same <input type="checkbox"/>	Not as well <input type="checkbox"/>

Has this changed since cancer diagnosis and treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is your child receiving any additional assistance to improve their reading skills? <input type="checkbox"/> Yes <input type="checkbox"/> No (please specify)
If your child has difficulty with fine motor coordination and control, are they receiving any additional assistance to improve these skills? <input type="checkbox"/> Yes <input type="checkbox"/> No (please specify)	

Compared to other children of the same age, does your child need extra assistance to:	Dress themselves <input type="checkbox"/>	Bath or shower themselves <input type="checkbox"/>	Toilet themselves <input type="checkbox"/>	Other self care tasks <input type="checkbox"/>
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Compared to other children of the same age, do you think your child's language skills are:	Better <input type="checkbox"/>	Same <input type="checkbox"/>	Not as good <input type="checkbox"/>
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Does your child have any of the following speech difficulties?

Slow to develop speech/ start speaking <input type="checkbox"/>	Slurred speech <input type="checkbox"/>	Stutter <input type="checkbox"/>	Lisp <input type="checkbox"/>	Limited vocabulary <input type="checkbox"/>	Speaks too quietly <input type="checkbox"/>	Difficulty finding the right words <input type="checkbox"/>	Difficulty putting words into sentences <input type="checkbox"/>
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If yes to any of the above, is your child receiving additional assistance to develop or improve language skills? (please specify)

Compared to other children of the same age, does your child appear to have any swallowing difficulties such as choking, excess dribbling etc?

**Nutrition**

Do you consider your child to be:	Overweight <input type="checkbox"/>	Average for height and age <input type="checkbox"/>	Underweight <input type="checkbox"/>
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Has this changed since cancer diagnosis and treatment?

Do you have any concerns about your child's appetite or eating behaviour? (please specify)

Are there any specific dietary, nutritional or eating behaviour issues you would like to discuss when you come to the LTF clinic?

**Quality of life**

Does your child have any ongoing issues with pain?  Yes  No (please specify)

Does your child have any difficulties sleeping?  Yes  No (please select any that apply)

Trouble getting to sleep <input type="checkbox"/>	Waking during the night <input type="checkbox"/>	Difficulty waking in the morning <input type="checkbox"/>	Falling asleep during the day <input type="checkbox"/>	Anxiety about sleeping in own bedroom <input type="checkbox"/>	Nightmares <input type="checkbox"/>	Other <input type="checkbox"/>
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Compared with other children of the same age, how well does your child play, interact and engage with peers?	Much more <input type="checkbox"/>	More <input type="checkbox"/>	The same <input type="checkbox"/>	Less <input type="checkbox"/>	Much less <input type="checkbox"/>
Has your child's social life changed since they were diagnosed and treated for cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No (please comment)					

Most of the time, how happy do you feel your child is?	Very happy <input type="checkbox"/>	Happy <input type="checkbox"/>	Neither happy nor unhappy <input type="checkbox"/>	Unhappy <input type="checkbox"/>	Unhappy very <input type="checkbox"/>
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Compared to other children of the same age, how confident do you feel your child is?	Extremely confident <input type="checkbox"/>	More confident <input type="checkbox"/>	Same <input type="checkbox"/>	Less confident <input type="checkbox"/>	Much less confident <input type="checkbox"/>
Do you have any concerns about your child's behaviour?					

Does your child talk about their health?	Often <input type="checkbox"/>	Only if asked <input type="checkbox"/>	Very rarely <input type="checkbox"/>
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Do you think your child worries about their cancer diagnosis and future impact?	Worries a lot <input type="checkbox"/>	Sometimes worries <input type="checkbox"/>	Worries a little <input type="checkbox"/>	Doesn't worry <input type="checkbox"/>
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Do you or other member of your family worry about anything related to your child's cancer diagnosis and future impact?	Worries a lot <input type="checkbox"/>	Sometimes worries <input type="checkbox"/>	Worries a little <input type="checkbox"/>	Doesn't worry <input type="checkbox"/>
Does this worry impact on your day to day life? <input type="checkbox"/> Yes <input type="checkbox"/> No				

Do you believe your child's cancer treatment has had an ongoing financial impact on your family? <input type="checkbox"/> Yes <input type="checkbox"/> No	Would you like to discuss this with the social worker at the LTF clinic? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Would you like a referral to a financial counselor through the LTF clinic? <input type="checkbox"/> Yes <input type="checkbox"/> No

Is there anything else about your child, their illness or activities you would like to tell me about?

Are there any specific questions or areas of concern that you would like addressed at the LTF clinic?