JGZ Zuid-Holland West
Consultatiebureau voor kind en jeugd

Health Survey group 2
Questionnaire for parents/care providers

How is your child? If there are any are points of interest for us to consider during the consultation, please let us know. Please complete this questionnaire and bring it with you to the consultation. We will discuss the questionnaire with you during the consultation at the JGZ Centre.

Name of your child: _____

Date of Birth: _____

Home telephone number: _____ Mobile number: _____

E-mail: _____

Name of school (+ location): _____

Group: _____ Instructor: _____

GP: _____

Questionnaire completed by: Mother/father/other, namely: _____ on *(date)*: _____

My child has been to a JGZ office in: _____ *(name of municipality)*

1 With whom does your child reside most of the days of the week? My child lives:

- ☐ with father and mother (together)
- ☐ with mother and her partner
- ☐ with father and his partner
- ☐ only with mother
- ☐ only with father
- ☐ other (i.e. foster parents, other family, orphanage), namely: _____

_____

2 Length of biological parents *(if known)*:

mother _____ cm, father _____ cm

3 Are there more children in the family?

- ☐ no
- ☐ yes, namely:

	First name	Last name	M/F	Date of birth
1				
2				
3				
4				
5				

4 Has your child undergone any changes since his/her last visit to the JGZ Centre (during the past 2 years)? (Such as: birth of a brother or sister, death of a family member, divorce, illness of a family member, changed, work situation, financial problems or a change of address)

☐ No ☐ Yes, namely: _____

Do you think your child has had difficulty with this?

☐ No ☐ Yes, namely: _____

5 Is there smoking in the house? ☐ Yes ☐ No

6 Some illnesses or disorders are more common in some families than others. Please cross off which of the following illnesses or disorders occur in your immediate family (parents, grandparents, brothers or sisters).

You may cross off as many boxes as necessary.

☐ Asthma/bronchitis
☐ Eczema
☐ Allergies/hay fever
☐ Epilepsy
☐ Learning disabilities
☐ Diabetes
☐ Psychiatric disorders
☐ Curved spine
☐ Lazy eye/cross-eye
☐ Hearing impairment prior to 40 years of age
☐ Congenital (heart-) disorders
☐ Mental disability
☐ Heart- /vascular diseases prior to 50 years of age
☐ Other diseases, namely: _____

7 Has your child been seriously ill or had an accident during the past 2 years? ☐ Yes ☐ No

If yes, which illness or what type of accident? _____

8 Generally speaking, how do you feel about the health of your child?

☐ very good ☐ good ☐ so-so ☐ not good ☐ very bad

Comments: _____

9 Are there any complaints or special concerns that you wish to report? ☐ Yes ☐ No

For example: often sick, respiratory problems (coughing, wheezing, congested), fatigue, un-well, no interest in school. If yes, please specify here: _____

10 Does your child see a doctor? ☐ Yes ☐ No

If yes, please specify which doctor and why. *(please cross off the correct answer and state the name of the doctor/therapist)*

☐ GP _____
☐ Specialist _____
☐ Physical therapist _____
☐ Speech therapist _____
☐ JGZ office _____
☐ Pedagogue _____
☐ Dietician _____
☐ Psychologist _____
☐ Alternative healer _____
☐ Other, namely _____

11 Does your child take any medicine? ☐ Yes ☐ No

If yes, please specify here: _____

12 My child eats:

A breakfast before going to school	☐ every day	☐ some days of the week	☐ never
Fruit	☐ every day	☐ a few times a week	☐ never
Vegetables	☐ every day	☐ a few times a week	☐ never
Dairy products (milk, yoghurt, etc.)	☐ every day	☐ some days of the week	☐ never
Meat or fish	☐ every day	☐ a few times a week	☐ never
Vegetarian	☐ every day	☐ a few times a week	☐ never
Extra vitamins	☐ every day	☐ a few times a week	☐ never

Comments: _____

13 Does your child have annual check-ups at the dentist? ☐ Yes ☐ No

14 How often does your child brush his/her teeth? _____ times per day

15 What time does your child go to bed?

During the week approx. _____ hours

In the weekends approx. _____ hours

16 Is your child well-rested in the mornings? ☐ Yes ☐ No

17 Is your child toilet trained? ☐ Yes ☐ No

Daytime ☐ Yes ☐ No

Night time ☐ Yes ☐ No

18 Is your child able to wipe his/herself? ☐ Yes ☐ No

Are bowel movements a problem? ☐ Yes ☐ No

If yes, please specify: _____

19

My child	Not true	Partly somewhat true	True
Plays well with other children (friends, brother, sister)	☐	☐	☐
Demands attention in a negative way	☐	☐	☐
Is regularly contradictory or stubborn	☐	☐	☐
Understands school assignments well	☐	☐	☐
Is able to concentrate	☐	☐	☐
Has difficulties with speech and language (for example, not pronouncing words well, stuttering or speaking very little)	☐	☐	☐
Has difficulty with the absence of parents (for example, when he/she plays at another child's house or during sleep-overs)	☐	☐	☐
Is routinely quiet or withdrawn	☐	☐	☐
Has sufficient self-confidence (in new situations, for example)	☐	☐	☐
Is scared of many things, is easily anxious	☐	☐	☐
Is often over-active or cannot sit still	☐	☐	☐
Is often disobedient	☐	☐	☐

20 Does your child ever exhibit behaviour which concerns you or you have difficulty with? ☐ Yes ☐ No

If yes, please indicate the type of behaviour: _____

21 Young children are discovering their own bodies and emotions, discovering the differences between boys and girls by playing sexually-oriented games.
Do you have any questions about the sexual development or behaviour of your child?

☐ No ☐ Yes, namely: _____

22 Does your child participate in any sports?

☐ No ☐ Yes, namely: _____

23 Does your child have any respiratory problems? ☐ Yes ☐ No
Does your child have his/her swim diploma? ☐ Yes ☐ No

24 Does your child go to childcare? ☐ Yes ☐ No
If yes, please specify here:
☐ After school Care ☐ Grandmother/father ☐ Babysit family/foster family
☐ Other, namely: _____

25 What does your child enjoy doing after school? _____

26 How much time does your child spend on a (gaming) computer/laptop/tablet/TV/smartphone?
☐ Never or shorter than 1 hour a day ☐ 2 to 3 hours a day
☐ Never or shorter than 2 hour a day ☐ 2 to 3 hours a day

27 Do you have any other concerns about your child?

☐ No ☐ Yes, namely: _____

28 Are there any topics you would like to discuss **without** your child being present?

☐ No ☐ Yes, namely: _____

Until next time at the JGZ Centre!

***Tip:** Information about the growth of children can be found on our website: www.jgzzhw.nl*