



School Entry Wellbeing Review

All personal information will remain confidential - Please use **BLOCK CAPITALS** in the boxes provided or use a cross to indicate your choice. (e.g. X).

Lifestyle Choices

How many helpings of fruit and vegetables does your child normally eat in one day? None 1-2 3-4 5 More than 5

How many times a week does your child eat red meat? Everyday 3-4 times Never 4-6 times 1-2 times

How often does your child eat a take away meal? More than once a week Rarely Weekly Never

Does your child have something to eat before school starts? Everyday 3-4 times Never 4-6 times 1-2 times

How often does your child have fizzy drinks or pop? With meals Between meals Never

How often does your child drink plain water? With meals Between meals Never

Have you any worries or concerns about your child's diet? Yes No

Would you like any help & support about your child's diet? Yes No

Would you like more information about healthy eating? Yes No

Does your child enjoy moderate physical activity? (for example, running, riding a bike, skipping) Yes No

How much moderate physical activity does your child do each day? At least one hour None Less than one hour

Have you any worries or concerns about your child's physical activity? Yes No

Would you like any help & support about your child's physical activity? Yes No

Would you like more information about physical activity? Yes No

Services & Choices

Do you want any information on any of the following? Behaviour Management Smoking Child Development Alcohol Parenting Drugs Sexual Health Solvents

Where would you like to access health information? Schools Children's Centres Health Centres/GP Youth Centres
Other

Where would you like health services delivered? Schools Children's Centres Health Centres/GP Youth Centres
Other

Personal Details

Child's Last Name (Surname)

Child's First Name (Forename)

Date of Birth (Day/Month/Year) / / Gender Male (Boy) Female (Girl)

Religion (Faith)

Child's Present School

Your Post Code Your Address

Contact Telephone Number

Ethnic Group Asian Black Chinese Mixed Race White Other

Universal Health

Does your child suffer from any of the following chronic conditions? Asthma Epilepsy Anaemia Eczema Diabetes Allergies
Other

Does your child have any problems with sensory development? Taste Smell Touch (Temperature) Vision Hearing Movement (Balance)

Does your child have problems with any of the following? Speech Sleeping Growth Learning Behaviour Bedwetting

Does your child have any registered disabilities? Yes No

Is your child currently being seen by any of the following professionals? Speech & Language Optician Hospital Consultant Audiologist

Are your child's immunisations up to date? Yes No

Are you worried about your child's physical development? Yes No

Within the last year has your child:
Had a check up at the dentist? Yes No
Had an emergency appointment at the dentist? Yes No

Have you any worries or concerns about your child's health? Yes No

Would you like any help & support about your child's health? Yes No

Would you like more information about health & wellbeing? Yes No

Risk & Protective Factors

Are you in paid employment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is your partner in paid employment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you rely on childcare?	<input type="checkbox"/> Before/After School Club <input type="checkbox"/> Childminder	<input type="checkbox"/> Grandparents <input type="checkbox"/> Friends
Where do you live?	<input type="checkbox"/> Own Home <input type="checkbox"/> Temporary Housing	<input type="checkbox"/> Supported Housing <input type="checkbox"/> Homeless
Is the house overcrowded?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Did you enjoy going to school?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Did you achieve all the qualifications you hoped to achieve?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you attended any further education courses?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
How does your child behave when you leave the room?	<input type="checkbox"/> Highly Distressed <input type="checkbox"/> Very Upset	<input type="checkbox"/> Slightly Upset <input type="checkbox"/> Not Upset
How does your child behave when you return to a room?	<input type="checkbox"/> Happy <input type="checkbox"/> Unsure/hesitant	<input type="checkbox"/> Not Bothered <input type="checkbox"/> Upset
Does your child engage/connect with strangers?	<input type="checkbox"/> Never	<input type="checkbox"/> Always <input type="checkbox"/> Sometimes
Has your child ever been to the accident and emergency department following an accident or serious injury?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has your child ever been admitted in to hospital following an accident or injury?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you any worries or concerns about your child's safety?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Would you like any help & support about your child's safety?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Would you like more information about accidents & safety?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Family Health

Do you have any registered disabilities?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does your partner have any registered disabilities?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you get support and help from family members?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have someone in the family you can talk to?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does your family give you advice & information?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does your family provide you with any financial support?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you get support and help from friends?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have friends you can talk to?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do your friends give you advice & information?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does anyone in your family have a long standing illness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Emotional Health & Wellbeing

Please give your answers about your child's behaviour over the last six months

Considerate of other people's feelings	<input type="checkbox"/> Not true	<input type="checkbox"/> Somewhat true	<input type="checkbox"/> Certainly true
Restless, overactive, cannot stay still for long	<input type="checkbox"/> Not true	<input type="checkbox"/> Somewhat true	<input type="checkbox"/> Certainly true
Often complains of headaches, stomach-aches or sickness	<input type="checkbox"/> Not true	<input type="checkbox"/> Somewhat true	<input type="checkbox"/> Certainly true
Shares readily with other children (treats, toys etc.)	<input type="checkbox"/> Not true	<input type="checkbox"/> Somewhat true	<input type="checkbox"/> Certainly true
Often has temper tantrums or hot tempers	<input type="checkbox"/> Not true	<input type="checkbox"/> Somewhat true	<input type="checkbox"/> Certainly true
Rather solitary, tends to play alone	<input type="checkbox"/> Not true	<input type="checkbox"/> Somewhat true	<input type="checkbox"/> Certainly true
Generally obedient, usually does what adults request	<input type="checkbox"/> Not true	<input type="checkbox"/> Somewhat true	<input type="checkbox"/> Certainly true
Many worries, often seems worried	<input type="checkbox"/> Not true	<input type="checkbox"/> Somewhat true	<input type="checkbox"/> Certainly true
Helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/> Not true	<input type="checkbox"/> Somewhat true	<input type="checkbox"/> Certainly true
Constantly fidgeting or squirming	<input type="checkbox"/> Not true	<input type="checkbox"/> Somewhat true	<input type="checkbox"/> Certainly true
Has at least one good friend	<input type="checkbox"/> Not true	<input type="checkbox"/> Somewhat true	<input type="checkbox"/> Certainly true
Often fights with other children or bullies them	<input type="checkbox"/> Not true	<input type="checkbox"/> Somewhat true	<input type="checkbox"/> Certainly true
Often unhappy, down-hearted or tearful	<input type="checkbox"/> Not true	<input type="checkbox"/> Somewhat true	<input type="checkbox"/> Certainly true
Generally liked by other children	<input type="checkbox"/> Not true	<input type="checkbox"/> Somewhat true	<input type="checkbox"/> Certainly true
Easily distracted, concentration wanders	<input type="checkbox"/> Not true	<input type="checkbox"/> Somewhat true	<input type="checkbox"/> Certainly true
Nervous or clingy in new situations, easily loses confidence	<input type="checkbox"/> Not true	<input type="checkbox"/> Somewhat true	<input type="checkbox"/> Certainly true
Kind to younger children	<input type="checkbox"/> Not true	<input type="checkbox"/> Somewhat true	<input type="checkbox"/> Certainly true
Often lies or cheats	<input type="checkbox"/> Not true	<input type="checkbox"/> Somewhat true	<input type="checkbox"/> Certainly true
Picked on or bullied by other children	<input type="checkbox"/> Not true	<input type="checkbox"/> Somewhat true	<input type="checkbox"/> Certainly true
Often volunteers to help others (parents, teachers, other children)	<input type="checkbox"/> Not true	<input type="checkbox"/> Somewhat true	<input type="checkbox"/> Certainly true
Thinks things out before acting	<input type="checkbox"/> Not true	<input type="checkbox"/> Somewhat true	<input type="checkbox"/> Certainly true
Steals from home, school or elsewhere	<input type="checkbox"/> Not true	<input type="checkbox"/> Somewhat true	<input type="checkbox"/> Certainly true
Gets on better with adults than with other children	<input type="checkbox"/> Not true	<input type="checkbox"/> Somewhat true	<input type="checkbox"/> Certainly true
Many fears, easily scared	<input type="checkbox"/> Not true	<input type="checkbox"/> Somewhat true	<input type="checkbox"/> Certainly true
Sees tasks through to the end, good attention span	<input type="checkbox"/> Not true	<input type="checkbox"/> Somewhat true	<input type="checkbox"/> Certainly true
Have you any worries or concerns about your child's emotional health?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Would you like any help & support about your child's emotional health?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Would you like more information about emotional health?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	