QEC

BRADMA LABEL

FAMILY HEALTH FORM

NAME OF PROGRAM:_____ DATE OF ADMISSION : _/__ /__

NAME OF PRIMARY CARER:_____ DATE OF BIRTH:__/__ /__

NAME OF SECONDARY CARER:_____ DATE OF BIRTH:__/__ /__

Name of your Local Maternal and Child Health

Name: _____

Address & Postcode_____

_____

Telephone/Mobile _____

Name of the Child's Local Doctor or and Paediatrician?

Name:_____

Address & Postcode_____

_____

Telephone/Mobile _____

	Primary Carer	**Secondary Carer**
Have you ever experienced any illness, injury or disability	☐ No ☐ Yes	☐ No ☐ Yes
that affects your family life? &/or parenthood? If so, please list them	_____ _____	_____ _____
Are you currently taking any tablets or medication? Please list them	☐ No ☐ Yes _____ _____	☐ No ☐ Yes _____ _____
Do you have any allergies? If so, please list them	☐ No ☐ Yes _____ _____	☐ No ☐ Yes _____ _____
Do you smoke cigarettes? Please indicate frequency:	☐ No ☐ Yes _____ _____	☐ No ☐ Yes _____ _____
Do you drink alcohol? Please indicate frequency:	☐ No ☐ Yes _____ _____	☐ No ☐ Yes _____ _____
Do you use other recreational drugs? Please indicate type and frequency	☐ No ☐ Yes _____ _____	☐ No ☐ Yes _____ _____

Have you experienced any major lifestyle event during the past year as a family?

☐ Self or Partner return to study ☐ Family illness/death ☐ Self or partner loss/change in employment
☐ Moving /renovating house ☐ Relationship changes ☐ Major Financial Change

Who provides the main support for you in your parent role?

Primary Carer_____

Secondary Carer_____

Please fill details of your Pregnancy/cies?

Year	Planned or Unplanned	Outcome TOP-miscarriage live birth/still birth	Was child born at term?	Type of delivery: Normal, Forceps, Caesarean, Breech
	☐ No ☐ Yes		☐ No ☐ Yes	
	☐ No ☐ Yes		☐ No ☐ Yes	
	☐ No ☐ Yes		☐ No ☐ Yes	
	☐ No ☐ Yes		☐ No ☐ Yes	

Were there any complications during any of the above pregnancies or birth? ☐ No ☐ Yes

_____

At present, how would you describe yourself in relation to the following? Please mark at any place along the line that best indicates how you feel?

Primary Carer

Physical Health Poor _____ /_____ Good
Sleep Pattern Poor _____/_____Sleep well
Appetite/Eating Poor _____ /_____ Good
Level of communication with partner Poor _____/_____Excellent

Secondary Carer

Physical Health Poor_____ /_____ Good
Sleep Pattern Poor _____/_____ Sleep well
Appetite/Eating Poor_____ /_____ Good
Level of communication with partner Poor _____/_____ Excellent

With the following please complete and indicate. Circle (0) for Primary Carer and Square ☐ for Secondary Carer

CHILD ONE

NAME: _____ **DATE OF BIRTH:** __/__ /__

Weight_____ **Type of Allergy** _____ **Reaction**_____

Childs Medication/s _____

Childs Illnesses/Additional Needs _____

		Very Happy	Happy	Mixed	Unhappy	Very Unhappy
						
Please circle a number to describe how you feel						
1.	How do you feel about the job of being a parent?	1	2	3	4	5
2.	How do you feel with the way you get along with your child?	1	2	3	4	5
3.	How do you feel about the way your child behaves?	1	2	3	4	5

With the following please complete and indicate. Circle (0) for Primary Carer and Square ☐ for Secondary Carer

CHILD TWO

NAME: _____ **DATE OF BIRTH:** __/__ /__

Weight_____ **Type of Allergy** _____ **Reaction**_____

Childs Medication/s _____

Childs Illnesses/Additional Needs _____

		Very Happy	Happy	Mixed	Unhappy	Very Unhappy
						
Please circle a number to describe how you feel						
1.	How do you feel about the job of being a parent?	1	2	3	4	5
2.	How do you feel with the way you get along with your child?	1	2	3	4	5
3.	How do you feel about the way your child behaves?	1	2	3	4	5

With the following please complete and indicate. Circle (0) for Primary Carer and Square ☐ for Secondary Carer

CHILD THREE

NAME: _____ **DATE OF BIRTH:** __/__ /__

Weight_____ **Type of Allergy** _____ **Reaction**_____

Childs Medication/s _____

Childs Illnesses/Additional Needs _____

		Very Happy	Happy	Mixed	Unhappy	Very Unhappy
						
Please circle a number to describe how you feel						
1.	How do you feel about the job of being a parent?	1	2	3	4	5
2.	How do you feel with the way you get along with your child?	1	2	3	4	5
3.	How do you feel about the way your child behaves?	1	2	3	4	5

This form is completed by: (Please print)

FORM TO BE COMPLETED & SIGNED BY CLIENT

Name: _____

Relationship to child/ren_____

Signature: _____

Date: ____/____ /____

COMPLETED BY QEC STAFF

Name: _____

Position: _____

Signature: _____

Date: ____/____ /____