



FAMILY BACKGROUND QUESTIONNAIRE - Course Date:

This questionnaire collects information about your family. Please read and answer every question. All information provided will be treated in strict confidence and will not be made available to any other source without your written approval.

Name

Address

Postcode

Telephone contact number

Today's date

Your Family

1. Child's name

2. Child's sex

Male

Female

3. Child's age today years

4. Child's date of birth

(day)

(month)

(year)

5. Your relationship to this child

Mother (biological or adoptive)

Step-mother

Foster mother

Father (biological or adoptive)

Step-father

Foster father

Other (please describe)

6. Your current marital status

Married

Defacto

Divorced

Civil Union

Separated

Never married/defacto

Widow/er

7. At present who lives at home with your child (e.g. parents, siblings, grandparents)?

Name	Age	Sex	Relationship to child

8. Which best describes the household in which your child is presently living?
 Original family (both biological or adoptive parents present)
 Step-family (two parents, one being a step-parent)
 Sole parent family
 Other (please describe)

Your Education and Employment

9. Your highest level of education

High School/college
 College certificate

Trade/apprenticeship qualification
 Tertiary qualification

10. Your partner's highest level of qualification (if applicable)

High School/college
 College certificate

Trade/apprenticeship qualification
 Tertiary qualification

11. Are you currently in paid employment?

Yes No If Yes, how many hours per week?hrs

12. Is your partner (if applicable) currently in paid employment?

Yes No If Yes, how many hours per week?hrs

13. Does your family receive any government benefit or pension?

Yes No

If Yes, please list

.....

Your Health

14. In the last 6 months have either you or your partner sought professional assistance from any of the following?

		Self		Partner
Psychologist	Yes	No	Yes	No
Psychiatrist	Yes	No	Yes	No
Counsellor	Yes	No	Yes	No
Social Worker	Yes	No	Yes	No
Other Professional	Yes	No	Yes	No

If Yes, please specify

.....

Your Child's Health

15. Does your child experience any of the following?

A vision or hearing impairment	Yes	No
A severe chronic illness that results in regular hospitalisation	Yes	No
A physical disability	Yes	No
An intellectual disability	Yes	No
A developmental delay	Yes	No
A restrictive/therapeutic diet prescribed by a health professional	Yes	No

If Yes to any of the above, please provide details

.....

.....

16. Is your child having any regular contact with another professional or government agency for emotional or behavioural problems? Yes No

If Yes, please describe

.....