

Surgery use only: Questionnaire checked by \_\_\_\_\_ (PLEASE PRINT NAME)



**New Patient Health Questionnaire – Under 16 years of age**

Dear Parent/Guardian....Thank you for registering your child/ward with St Catherine's Surgery and please could you complete this questionnaire as fully as possible.

**Child's details:-**

Name: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Male: \_\_\_\_\_ Female: \_\_\_\_\_

Address: \_\_\_\_\_

Postcode: \_\_\_\_\_

Name of school attended: \_\_\_\_\_

Ethnicity (Please tick below):

White: \_\_\_\_ Asian: \_\_\_\_ Black: \_\_\_\_ Chinese: \_\_\_\_ Mixed (white/black, white/asian, other): \_\_\_\_  
Other: \_\_\_\_

Name of Health Visitor if applicable: \_\_\_\_\_

Does the child or yourself have any involvement with social services? YES/NO (If yes please see below)

Please provide details including a contact at social service if known:

\_\_\_\_\_

**Your details:**

Name: \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_

Postcode: \_\_\_\_\_

Telephone numbers:

Home: \_\_\_\_\_ / Mobile: \_\_\_\_\_ / Work: \_\_\_\_\_

Email address: \_\_\_\_\_

Are you the person with parental responsibility? : YES/NO (If no please detail below)

\_\_\_\_\_

If you have provided a mobile telephone number we will send you a text reminder about your child's/ward's appointments and health care updates. Please tick here if you **DO NOT** consent to this service: \_\_\_\_\_

To help ensure quality of access to relevant information or communications sent by the surgery, please advise us of any special requirements you may have, for example large print text.

\_\_\_\_\_

Thank you