Clear form

Preliminary information form – new client at the child health clinic

In addition to monitoring the child's development and growth, the child health clinic is tasked with promoting the wellbeing of parents and custodians as well as supporting upbringing work and a safe growing environment. The wellbeing and way of life of the parents and the whole family have an impact on the child's everyday life. As a result, the child health clinic also asks about factors related to the wellbeing of the parents and discusses the family's overall situation.

We hope you will fill out this form and take it with you to the child health clinic appointment. When the child is living in two homes, a separate form can be filled out in both of them. We will discuss the topics on the form during the health examination. Your answers will help direct the examination to the needs and wishes of your family.

Filling out the form and answering each individual question is voluntary. The information you provide is confidential and subject to health care confidentiality provisions. The health examination will be documented in patient records, after which this form will be disposed of. The documents of the child health clinic are part of the patient register of the wellbeing services county.

Basic information	
Child's name	
Child's personal identity number	
Child's native language	
Other languages spoken in the family	
Names of the parents/custodians	
Telephone number(s) of the parents/custodians	
The child lives	
☐	with both parents
☐	with one parent (please describe the housing arrangements in more detail)
☐	alternate housing (please describe the housing arrangements in more detail)
☐	other arrangement (please describe the housing arrangements in more detail)
Changes in the structure of the family	
☐	no changes
☐	dissolution of common law marriage / divorce (joint custody / single custody, in which year the change took place)
☐	new common-law marriage / marriage
☐	other change, what? (please describe in more detail)

Siblings of the child and their years of birth			
Other persons in the family or household			
Everyday life			
Is the child in daycare?			
☐	no	☐	daycare centre
☐	family daycare centre	☐	at the childminder's home
Does your child like being in daycare?			
☐	yes	☐	no
☐	I am not sure		
How do you perceive the child's state of health?			
Does your child have a long-term (physical or psychological) symptom, illness or injury?			
☐	no	☐	yes
What symptoms, illnesses or injuries does your child have?			
Current treatments for your child			
Which parties are responsible for the treatment?			
Potential restrictions of your child			

Does your child have a special diet?
Does your child have allergies?
Does your child use any medication continuously?

☐	no	☐	yes

What continuous medication does your child take?
What are the good things in your family's health habits (sleep, nutrition, activity, use of media)?
What are the things that would require improvement in your family's health habits (sleep, nutrition, activity, use of media)?
My child's teeth are brushed with fluoride toothpaste

☐	not at all
☐	less often than once a day
☐	once a day
☐	two times a day
☐	more than two times a day

How is the everyday life of your family going? How does your family usually spend time together?

What things in your child make you happy?
How do you feel about the growth and development of your child? Do you have any concerns about the child's growth and development?
Has the daily life of the child or family changed in some way during the past six months?
How do you feel about your own coping in the family's everyday life?

Parent's relationship/partnership

The child health clinic intends to support parenthood in taking good care of the child and in taking care of the couple's relationship. The parent's relationship/partnership has an impact on the parent's resources, which is why the child health clinic also asks about the status of the parent's close relationships.

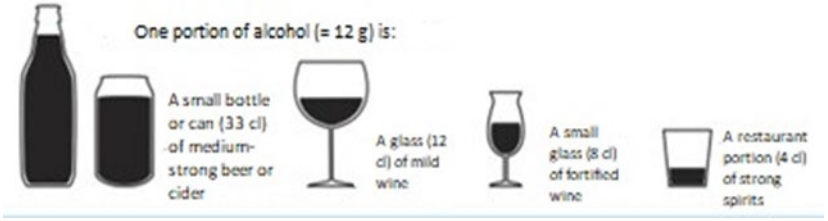
Are you in a relationship/partnership?

☐	yes
☐	no

	I completely agree	I partially agree	I partially disagree	I completely disagree
We have a good conversational connection	☐	☐	☐	☐
We have enough time together.	☐	☐	☐	☐
I am happy with our sexual life.	☐	☐	☐	☐
We have a close relationship.	☐	☐	☐	☐
I am happy with my relationship.	☐	☐	☐	☐
Housework is divided fairly in our family.	☐	☐	☐	☐
We take turns in taking care of the child from time to time.	☐	☐	☐	☐
We try to do nice things together.	☐	☐	☐	☐

Use of intoxicants by the parents			
The parent's abuse of intoxicants may also affect the child's health and wellbeing, which is why these factors are surveyed at the child health clinic.			
Nicotine products are used in our family.			
☐	no		
☐	yes		
Which nicotine products are used in your family?			
☐	tobacco	☐	e-cigarettes
☐	nicotine bag	☐	snuff
☐	nicotine replacement product		
Who in your family uses nicotine products?			
☐	I	☐	another family member
Is your child exposed to tobacco smoke?			
☐	no	☐	yes
Alcohol is used in our family			
☐	no	☐	yes
Who in your family uses alcohol?			
☐	I	☐	another family member
By answering the questions of the AUDIT questionnaire, you can get a comprehensive idea of the potential risks and disadvantages of drinking. Choose the option that best corresponds to your situation. The questions in the questionnaire refer to the past year.			

AUDIT questionnaire	
1. How often do you drink beer, wine or other alcoholic beverages? Include also those occasions when you only drink small amounts of beer, such as a bottle of medium-strong beer or a small amount of wine.	
☐	Never (0 points)
☐	Once a month or less (1 point)
☐	2–4 times a month (2 points)
☐	2–3 times a week (3 points)
☐	4 times a week or more often (4 points)
2. How many portions of alcohol do you usually use on the days when you drink alcohol?	
☐	1–2 portions (0 points)
☐	3–4 portions (1 point)
☐	5–6 portions (2 points)
☐	7–9 portions (3 points)
☐	10 portions or more (4 points)
3. How often do you drink six or more portions of alcohol at a time?	
☐	Never (0 points)
☐	Less often than once a month (1 point)
☐	Once a month (2 points)
☐	Once a week (3 points)
☐	Daily or almost daily (4 points)
4. How often in the past year have you been unable to stop drinking alcohol once you started drinking?	
☐	Never (0 points)
☐	Less often than once a month (1 point)
☐	Once a month (2 points)
☐	Once a week (3 points)
☐	Daily or almost daily (4 points)
5. How often in the past year have you failed to take care of something that you normally should have taken care of because of your drinking?	
☐	Never (0 points)
☐	Less often than once a month (1 point)
☐	Once a month (2 points)
☐	Once a week (3 points)
☐	Daily or almost daily (4 points)



AUDIT questionnaire	
6. How often in the past year have you needed a portion of alcohol in the morning after heavy drinking to get yourself started?	
☐	Never (0 points)
☐	Less often than once a month (1 point)
☐	Once a month (2 points)
☐	Once a week (3 points)
☐	Daily or almost daily (4 points)
7. How often in the past year have you felt guilty or remorse after drinking?	
☐	Never (0 points)
☐	Less often than once a month (1 point)
☐	Once a month (2 points)
☐	Once a week (3 points)
☐	Daily or almost daily (4 points)
8. How often in the past year have you been unable to remember the next day what has happened because you had been drinking alcohol?	
☐	Never (0 points)
☐	Less often than once a month (1 point)
☐	Once a month (2 points)
☐	Once a week (3 points)
☐	Daily or almost daily (4 points)
9. Have you yourself or has someone else been injured because of your use of alcohol?	
☐	No (0 points)
☐	Yes, but not in the past year (2 points)
☐	Yes, in the past year (4 points)
10. Has someone close to you or your friend, doctor or other health care professional been worried about your use of alcohol or suggested that you should reduce your drinking?	
☐	No (0 points)
☐	Yes, but not in the past year (2 points)
☐	Yes, in the past year (4 points)
Total score 0-7 points: Your alcohol consumption is under control 8-13 points: Your alcohol consumption is abundant 14 points or more: Substance dependence is likely. You must reduce your use of alcohol.	

Narcotics (medicines, drugs) are used in our family			
☐	no	☐	yes
Who in your family uses narcotics?			
☐	I	☐	another family member
Survey of intimate partner violence			
The child health clinic always asks the parent about intimate partner violence in conjunction with a comprehensive health examination of the child or in the case of a new client.			
Is there domestic violence or psychological and/or physical abuse in your family?			
☐	no / not known	☐	between siblings
☐	yes, targeted at children		
The following questions are addressed to the parent who is filling in the form			
Have you been exposed to physical, mental or sexual violence or abuse in your close relationships at any point in your life?			
☐	yes	☐	no
Does the violence you have experienced still affect your health, wellbeing or life management?			
☐	yes	☐	no
Do your close relationships currently involve physical, mental or sexual violence or abuse?			
☐	Yes	☐	no
Family resources			
The following things empower your family:			
The following things burden your family:			
I would also like to say the following:			
Wishes for the health examination:			

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