

Practising Members of The Speech Pathology Association of Australia

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| **PARENT QUESTIONNAIRE**  Background Information | | | | | | | | | | | | | | | | | |
| **Appointment Date:** | | | | |  | | | | | | | **Therapist:** | | | | |  |
| **Child’s Full Name:** | | |  | | | | | | | | | | | | | | |
| Country of Birth: | | |  | | | | | | | | | Date of Birth: | | | | |  |
| Address: | | |  | | | | | | | | |  | | | | |  |
| Suburb: | | |  | | | | | | | | | Postcode: | | | | |  |
| Contact Phone  Numbers: | | | Home: | | | |  | | | | | Mobile - Mother: | | | | |  |
| Work: | | | |  | | | | | Mobile – Father: | | | | |  |
| Email Address: | | |  | | | | | | | | | | | | | | |
| **Father’s Name:** | | |  | | | | | | | | | | | | Age: | |  |
| Country of Birth: | | |  | | | | | | | | | | | | | | |
| Current Occupation: | | |  | | | | | | |  | | | | |  | | |
| **Mother’s Name:** | | |  | | | | | | | | | | | | Age: | |  |
| Country of Birth: | | |  | | | | | | | | | | | | | | |
| Occupation: | | |  | | | | | | |  | | | | |  | | |
| **Are there any legal orders in place for your child? YES/NO If yes, please attach orders** | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| **Who suggested you contact this centre?** | | | | | | | | | | | | | | | | | |
| **Name of Family Doctor:** | | | | | | | | | | | | | Contact No: | | | | |
| Address: |  | | | | | | | | | | | | | | | | |
| Suburb: |  | | | | | | | | | | | | Postcode: | | | |  |
| School/Preschool child attends: | | | | | | | |  | | | | | | | | | |
| Name of Teacher: | |  | | | | | | | | | | | Grade: | |  | | |
| Which days do they attend? | | | | | |  | | | | | | | | | | | |
| **Other children in the family:** | | | | | | | | | | | | | | | | | |
| **Name** | | | | **Age** | | **Grade** | | | **Difficulties** *(please tick)* | | | | | | | | |
| Language | | Reading/Spelling | | | Self-care | | Motor Movement | |
|  | | | |  | |  | | |  | |  | | |  | |  | |
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| **Health Fund Details: Name: Extras Cover: YES / NO** | | | | | | | | | | | | | | | | | |
| **Member No:** | | | | | | | | | | | | | | | | | |
| **Are you currently receiving a Centrelink Carer’s Allowance? 🞎** **YES 🞎NO**  *(please tick)* | | | | | | | | | | | | | | | | | |

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| --- |
| **PREGNANCY & BIRTH HISTORY** |

Did you experience any problems during pregnancy? 🞎 YES 🞎 NO

Nature of problems:

Was your child premature? **🞎** **YES** **🞎** **NO**  Gestation: (weeks)

Were there any problems during labour or birth? 🞎 YES 🞎 NO

Nature of problems:

Did your baby require assistance with the delivery? 🞎 YES 🞎 NO

Details:

Was treatment required after birth? 🞎 YES 🞎 NO

Nature of treatment:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Was your baby breast fed? | **🞎** YES **🞎** NO D | **YES** | **🞎** YES **🞎** NO D | **NO** | Until what age? |
| Was your baby bottle fed? | **🞎** YES **🞎** NO D | **YES** | **🞎** YES **🞎** NO D | **NO** | Until what age? |

Did your baby have any feeding problems? 🞎 YES 🞎 NO

(e.g. vomiting, reflux or difficulty with sucking)

Nature of Problems:

Did your baby transition easily to solids? 🞎 YES 🞎 NO

Details:

Does your child now tolerate a range of food types & textures? 🞎 YES 🞎 NO

Details:

Does your child frequently gag on solids? 🞎 YES 🞎 NO

Details:

What age did your child cease using a teated bottle for fluids? Months

Did your child use a dummy/pacifier? 🞎 YES 🞎 NO

What age did your child cease (completely) using it?

If your child is currently using a dummy, how often is it used?

Does your child dribble? 🞎 YES 🞎 NO

Details:

# **DEVELOPMENT**

At what age did your child first sit alone without support?

At what age did your child first crawl?

At what age did your child walk unaided?

At what age was your child toilet trained? 🞎 **Day** 🞎 **Night**

Does your child seem awkward, un-coordinated? 🞎 YES 🞎 NO

**Do you have any concern for your child in regards to the following?**

Hand dominance: e.g. swapping hands during tasks

Details:

Fine motor skills: using their hands and fingers e.g. holding a pencil, managing buttons and zippers, picking up small objects or strength of hand and fingers.

Details:

Gross motor skills: big movements e.g. running, jumping, hopping, climbing or ball skills

Details:

Planning and organisation: e.g. sequencing during daily activities.

Details:

Sensory issues: e.g. aversion or attraction to sound, touch or specific items.

Details:

Play skills: e.g. whether plays by self or alongside others or quality of play.

Details:

Self-care: e.g. brushing teeth, dressing or toileting.

Details:

# **MEDICAL HISTORY**

What illnesses and/or accidents has your child had?

|  |  |  |
| --- | --- | --- |
| Type of Illness | Age | Treatment |
|  |  |  |
|  |  |  |
|  |  |  |

Has your child ever had a convulsion? 🞎 YES 🞎 NO

Details:

Does your child have difficulties with attention and concentration? 🞎 YES 🞎 NO

Details:

How often does your child have colds? 🞎 Often 🞎 Sometimes 🞎 Never

Details:

Is your child presently on any medication? 🞎 YES 🞎 NO

If yes, what type of medication and for what reason?

Does your child have a physical disability? 🞎 YES 🞎 NO

Details:

Has your child had a hearing test? 🞎 YES 🞎 NO

If yes, when and where?

What were the results?

Has your child had repeated ear infections? 🞎 YES 🞎 NO

Details:

Has your child been seen by any other health professionals?

Please detail who, when and the reason?

Details:

Occupational Therapist 🞎 YES 🞎 NO

Details:

Psychologist 🞎 YES 🞎 NO

Details:

Paediatrician 🞎 YES 🞎 NO

Details:

Physiotherapist 🞎 YES 🞎 NO

Details:

**ENT 🞎 YES** **🞎 NO**

Details:

Please attach any relevant reports prior to the assessment

# **SPEECH and LANGUAGE**

**Describe in your own words your child’s difficulties:**

Has anyone else in the family ever had a speech / language / literacy / learning difficulty?

Did your child babble regularly as a baby? 🞎 YES 🞎 NO

At what age did your child say their first words?

What were they?

Did your child keep adding words once they started to talk? 🞎 YES 🞎 NO

Details:

At what age did your child make small sentences such as: “want drink” or “me go”

Has there been a change in their speech in the last

3 months? 🞎 YES 🞎 NO

Details:

Has your child received speech pathology services in the past? 🞎 YES 🞎 NO

Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are there any problems at school? 🞎 YES 🞎 NO

*e.g. reading, writing, spelling, socialising or communication?*

Details:

Does your child receive assistance or support at school? 🞎 YES 🞎 NO

Details:

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Is there any other language spoken at home

(apart from English)? 🞎 YES 🞎 NO

If yes, what language?

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Does your child understand and/or speak this language? 🞎 YES 🞎 NO

Details:

Please outline any further concerns you may have:

***Thank you***

***Speech-Language Pathology &***

***Occupational Therapy Team***