SPEECH IN FOCUS
Speech Pathology Services
Changing the individual's life and enhancing their world.

Shop1, 41- 43 Knox Street
Belmore NSW 2192

T: 02 8065 1197 F: 02 8088 7649
Website: www.speechinfocus.com.au
Email: info@speechinfocus.com.au
ABN: 21 119 666 036

Client Questionnaire

Download this file to your computer, open it using Adobe Acrobat Reader, save and e-mail the file to info@speechinfocus.com.au

Information about your child

Client's Name			
Date of Birth			
Address			
Health Fund Details			
Referred by			
Mother's Name		Age	
Mother's Mobile No			
Mother's E-mail			
Father's Name		Age	
Father's Mobile No			
Father's E-mail			
List the people and their age that are living at home with your child (**please advise if parents are no longer living together**)			
Family Doctor			
Telephone Number			
Address			
School/ Early Childhood Centre			
Telephone number			
Teacher / Director			
Days of week attending			

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Speech and Language

What concerns you about your child's speech and language?	
Did your child make noises / babble/ coo regularly as a baby?	Make a Selection...
When did your child say their first words?	
What were they?	
Did your child keep learning words once they started to talk?	Make a Selection...
When did your child make small sentences such as: "want drink" or "me go", "more bikkie"?	
Has there been an improvement or change in their speech and language over time? Please explain.	
What activities does your child like to do?	
What other language is spoken at home?	
Does your child understand the second language?	Make a Selection...
Does your child use the second language?	Make a Selection...
Do relatives, friends or strangers understand your child? Please describe:	

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Pregnancy & Birth History

Did you experience any problems during pregnancy or during birth?	Make Selection...
If so, please describe:	
Was your child breast fed?	Make a Selection...
If so, until what age?	
Was your child bottle fed?	Make Selection...
When did your child stop drinking from the bottle?	
Did your child have any feeding problems? (Eg: Sucking, attachment, reflux, gagging)	Make Selection...
If yes, please describe:	

Development

At what age did your child sit alone without support?	
At what age did your child crawl?	
At what age did your child walk?	
Is your child toilet trained?	Make a Selection...
Does your child have day sleeps?	Make a Selection...
What time do they sleep at night and wake in the morning?	
Are there any other concerns with <u>your child's development</u> apart from their speech and language?	

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Did your child transition easily to solids?	Make a Selection...
Please describe any difficulties experienced.	
Does your child tolerate a range of food types & textures?	Make a Selection...
Please describe:	
Does your child have any dental issues?	Make a Selection...
Please describe:	
Did your child use a dummy or thumb suck?	Make a Selection...
If yes, when is the dummy being used or thumb sucking occurring? When did your child stop using the dummy or suck their thumb?	

Education

What are the teacher's concerns?
Describe the type of assistance they are receiving at school/ early childhood centre.
Who helps your child with learning at home?

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Medical History	
How often does your child have colds?	Make a Selection...
Please list **any diagnosis,** conditions or illnesses or operations.	
Please describe any regular medication your child requires.	
Hearing	
What were the results of your child's last hearing test?	
Date:	
Where:	
Vision	
Does your child require glasses?	Make a Selection...
Reason:	
Dental	
Please describe any orthodontic or dental care your child has received.	
Developmental or Psychological Assessment	
Please describe the results of your child's developmental or psychological assessment, or attach a copy of the report.	

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✓ Please tick the types of difficulties **any members of your or your child's family /relatives** have:

Family & Relative		Difficulties						
Name	Age	Speech Sounds	Stuttering	Delayed language /Late talker	Hearing / Voice	Reading/ Spelling	Learning Difficulties	Autism
		☐	☐	☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐	☐	☐
		☐	☐	☐	☐	☐	☐	☐

Please provide the **name** of the professionals your child has seen.

Name of professional	When / how often	Name of professional	When / how often
Psychologist		School Counsellor	
Paediatrician		Behavioural Optometrist	
Occupational Therapist		Chiropractor	
Physiotherapist		Dentist/Orthodontist	
Ear Nose Throat Specialist		Speech Pathologist	
Tuition Service		Other	