SPEECH ON EYRE
Private Practice in Speech Therapy

Date:

PARENT QUESTIONNAIRE

This questionnaire was developed to gain some information prior to your initial session with Speech On Eyre as information about your child is important to create an individualised plan for your child. Please bring with you at your scheduled appointment.

CHILDS DETAILS

First Name:	Last Name:	
Gender: ☐ Male ☐ Female ☐ Other	Date of Birth:	Age:
Name of Parent/s/Carer		

CONTACT INFORMATION

Child's Postal Address:		
Phone:	Email:	Mobile:

SIBLINGS

Name	Age
Sibling 1	
Sibling 2	
Sibling 3	

MEDICAL DETAILS

Family Doctor:	Doctor's Provider Number:
Doctor's Number:	Doctor's Email:
Doctor's Address	
Is your child under Medicare plan? ☐ No ☐ Yes (If yes, please provide the following information) Date of Referral:	

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Other professionals on plan:	Name:	
	Profession:	
	Frequency of visits:	
	Contact Information:	
NDIA Goals:		

SCHOOL/CHILDCARE ATTENDING

Name of School:	Teacher:	Year level:
Name SSO (or other) assisting child at school:		

DEVELOPMENTAL HISTORY

Developmental History: What at age did your child complete the following:

Sitting:	Crawling:	Walking:
First words:	Put words together:	

How does your child get along with other children?
What would consider your child's strengths?

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Has your child seen a Speech Pathologist prior to this visit?: ☐ Yes ☐ No	When: Whom: Facility: Date of Discharge:
Goals targeted:	

Possible Reasons for Attending Speech on Eyre:

- ☐ Difficult to understand
- ☐ Not talking
- ☐ Difficulty saying some sounds. If so, which ones:
- ☐ Not saying single words
- ☐ Not putting words together
- ☐ Difficulties following directions
- ☐ Repeats sounds, words or parts of words
- ☐ Dribbling
- ☐ Difficulties eating a variety of foods
- ☐ Other:

Has anyone ever commented on your child's speech? If so, who commented and what was said?

MEDICAL HISTORY

Is your child currently on any medications?	☐ Yes	☐ No
	What are the medications for:	
Presence of ear infections?	☐ Yes	☐ No
Has hearing been evaluated?	☐ Yes	☐ No
	If so, when and what were results and recommendations:	

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History of grommets?	☐ Yes ☐ No If so, what is the current status and recommendations?
Has vision ever been tested?	☐ Yes ☐ No If so, when and what were the results/ recommendations?
Any surgeries?	☐ Yes ☐ No If yes, when and what surgery was performed?
Any other information that may assist in your child's speech therapy program?