

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: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	Date of Birth:	Age:
Name of Parent/s/Carer		

CONTACT INFORMATION

Child's Postal Address:		
<div style="border-bottom: 1px solid black; margin-bottom: 5px;"></div> <div style="border-bottom: 1px solid black; margin-bottom: 5px;"></div>		
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? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, please provide the following information)	
Date of Referral:	



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

SCHOOL/CHILDCARE ATTENDING

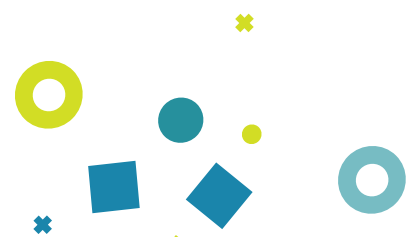
Name of School:	Teacher:	Year level:
Name SSO (or other) assisting child at school:		

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?



<p>Has your child seen a Speech Pathologist prior to this visit?:</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="background-color: #d9ead3; padding: 2px;">When:</td> <td style="border-bottom: 1px solid black; width: 90%;"></td> </tr> <tr> <td style="background-color: #d9ead3; padding: 2px;">Whom:</td> <td style="border-bottom: 1px solid black;"></td> </tr> <tr> <td style="background-color: #d9ead3; padding: 2px;">Facility:</td> <td style="border-bottom: 1px solid black;"></td> </tr> <tr> <td style="background-color: #d9ead3; padding: 2px;">Date of Discharge:</td> <td style="border-bottom: 1px solid black;"></td> </tr> </table>	When:		Whom:		Facility:		Date of Discharge:	
When:									
Whom:									
Facility:									
Date of Discharge:									
<p>Goals targeted:</p> <hr/> <hr/>									

<p>Possible Reasons for Attending Speech on Eyre:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"><input type="checkbox"/> Difficult to understand</td> <td style="width: 50%; border: none;"><input type="checkbox"/> Difficulties following directions</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Not talking</td> <td style="border: none;"><input type="checkbox"/> Repeats sounds, words or parts of words</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Difficulty saying some sounds. If so, which ones:</td> <td style="border: none;"><input type="checkbox"/> Dribbling</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Not saying single words</td> <td style="border: none;"><input type="checkbox"/> Difficulties eating a variety of foods</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Not putting words together</td> <td style="border: none;"><input type="checkbox"/> Other:</td> </tr> </table>	<input type="checkbox"/> Difficult to understand	<input type="checkbox"/> Difficulties following directions	<input type="checkbox"/> Not talking	<input type="checkbox"/> Repeats sounds, words or parts of words	<input type="checkbox"/> Difficulty saying some sounds. If so, which ones:	<input type="checkbox"/> Dribbling	<input type="checkbox"/> Not saying single words	<input type="checkbox"/> Difficulties eating a variety of foods	<input type="checkbox"/> Not putting words together	<input type="checkbox"/> Other:
<input type="checkbox"/> Difficult to understand	<input type="checkbox"/> Difficulties following directions									
<input type="checkbox"/> Not talking	<input type="checkbox"/> Repeats sounds, words or parts of words									
<input type="checkbox"/> Difficulty saying some sounds. If so, which ones:	<input type="checkbox"/> Dribbling									
<input type="checkbox"/> Not saying single words	<input type="checkbox"/> Difficulties eating a variety of foods									
<input type="checkbox"/> Not putting words together	<input type="checkbox"/> Other:									
<p>Has anyone ever commented on your child's speech? If so, who commented and what was said?</p> <hr/> <hr/> <hr/>										

MEDICAL HISTORY

<p>Is your child currently on any medications?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>What are the medications for:</p> <hr/> <hr/>
<p>Presence of ear infections?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Has hearing been evaluated?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If so, when and what were results and recommendations:</p> <hr/> <hr/>



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?

