Let's talk Let's eat

SPEECH PATHOLOGY

Please fill out this questionnaire as fully as you can. **Please return it to us at least 72 hours before your child's initial appointment** so we can tailor the assessment to your concerns. All answers and supporting information will be kept in strict confidence as part of your child's health records and subject to our privacy policy.

Summary of steps: Complete this questionnaire → Attend an assessment with your child, focusing on your concerns → We report our key findings and practical evidence-based recommendations about your child's therapy goals (if appropriate) → We discuss the assessment/report with you → We agree therapy goals with you and start therapy (if appropriate)

PARENT/CARER QUESTIONNAIRE

INFORMATION ABOUT YOUR CHILD

Child's full name:		Preferred name:	
Date of birth:	Age:	Gender: Male☐ Female ☐	Country of birth:
Address:		Postcode:	
Name of School/Pre-School/Childcare:			
Year/Class:	Teacher:	If applicable, which days does your child attend Pre-School/Childcare:	

YOUR DETAILS

PARENT/CARER 1	PARENT/CARER 2
Name:	Name:
Occupation:	Occupation:
Mobile phone number:	Mobile phone number:
Email address:	Email address:
Country of birth:	Country of birth:

NDIS INFORMATION

NDIS Number:			
How your plan is managed:	Portal ☐	3rd Party Managed ☐	Self-Managed ☐
3rd Party Manager:			
3rd Party Email to send Invoices:			
Plan start date:		Plan end date:	

MEDICARE AND HEALTH FUND DETAILS

Medicare number:	
Health fund:	Health fund membership number:

YOUR CHILD'S STRENGTHS AND CHALLENGES

Please describe your child's personality and strengths:
Please describe your main concerns about your child's communication:
When did you first become concerned?

What is your opinion about the cause of the issue?

FAMILY HISTORY INFORMATION

Are there any instances of hearing, speech-language, stuttering, voice or learning difficulties in the family (siblings, parents, uncles, aunts, grandparents etc.)? Yes ☐ No ☐
If yes, please describe:

OTHER INFORMATION

Who filled out this form?	Who referred you to us?
Are there any parenting plans or Court orders in place in relation to the custody, health or wellbeing of your child? Yes ☐ No ☐	If yes, please provide a copy to us.

PRENATAL AND BIRTH INFORMATION

Describe any difficulties experienced during the pregnancy or birth that may have impacted your child's development, e.g. prematurity:

Birth order: does your child have any siblings? Yes ☐ No ☐. If yes, please provide details:

Sibling's Name	Age	School Year	Language Speech Difficulties (Please tick/describe) Reading	Spelling	Other	Describe
			☐	☐	☐	
			☐	☐	☐	
			☐	☐	☐	
			☐	☐	☐	
			☐	☐	☐	

POST-BIRTH INFORMATION

Child's birth weight:

Did your child have any trouble starting to breathe? Yes ☐ No ☐	If yes, please provide details:
Did your child have any early feeding issues? (e.g. swallowing or sucking difficulty, reflux, vomiting) Yes ☐ No ☐	If yes, please describe:
Was your baby breast-fed? Yes ☐ No ☐	Until what age?
Was your baby bottle-fed? Yes ☐ No ☐	Until what age?
Did your child have any difficulty:	• nursing or taking a bottle? Yes ☐ No ☐
	• with lip or tongue tie? Yes ☐ No ☐
	• with reflux? Yes ☐ No ☐
	• transitioning to baby food? Yes ☐ No ☐
	• eating solid food? Yes ☐ No ☐
	• drinking from a cup? Yes ☐ No ☐

	• drinking from a straw? Yes ☐ No ☐
	• chewing, swallowing or clearing food from his/her mouth? Yes ☐ No ☐
	• tolerating a variety of food textures and tastes? Yes ☐ No ☐
	If yes to any of the above, please provide details:
EARLY DEVELOPMENT	
At what age (approximately) did your child first:	• sleep through the night regularly?
	• sit without support?
	• crawl?
	• commence solids?
	• regularly accept finger foods?
	• drink from an open cup?
	• walk without assistance?
	• feed themselves with a spoon?
At what age was your child toilet-trained?	Day: Night:
Does your child seem clumsy or uncoordinated? Yes ☐ No ☐	If yes, please provide details:
LANGUAGE DEVELOPMENT	
Language(s) spoken at home and with extended family members:	Main language spoken at home with primary carer:
Did your child babble regularly as a child? Yes ☐ No ☐	
At what age did you child first:	• say words?
	• use 2-word phrases to communicate? e.g. 'Mummy eat?', 'Me go?'
	• know and use 50 different words?
	• use sentences? e.g. 'The car is noisy.'
How does your child express his/her ideas?	
Does your child seem to have trouble:	• understanding and following instructions? Yes ☐ No ☐
	• understanding story sequences? Yes ☐ No ☐
	• finding the 'right words'? Yes ☐ No ☐
	• socialising with peers? Yes ☐ No ☐. If yes, please describe:

Let's talk Let's eat

SPEECH PATHOLOGY

SPEECH DEVELOPMENT/INTELLIGIBILITY	
Do strangers have difficulty understanding your child? Yes ☐ No ☐	
Have you noticed particular sounds or words your child has difficulty with? Yes ☐ No ☐	If yes, what are they? Can you provide any examples?
Has your child ever spoken better than he/she does now? Yes ☐ No ☐	If yes, please provide details:
Has there been a change in your child's speech in the last three months? Yes ☐ No ☐	If yes, please describe:

VOICE	
Is your child's voice:	• hoarse or strained? Yes ☐ No ☐
	• nasal? Yes ☐ No ☐
	• often too soft? Yes ☐ No ☐
	• often too loud? Yes ☐ No ☐
	• unusually high-pitched? Yes ☐ No ☐
	• unusually low-pitched? Yes ☐ No ☐

STUTTERING/FLUENCY	
Does your child stutter, get stuck on words, repeat sounds, syllables or words, or re-start sentences? Yes ☐ No ☐	If yes, please provide details on when it started, how it sounds:

COMMUNICATION ISSUES	
Does your child seem to be aware of his/her communication issues? Yes ☐ No ☐	If yes, please describe:
Has your child had a speech-language assessment or speech therapy before? Yes ☐ No ☐ **If you have any speech pathology reports, please provide a copy to us so we have the background information to tailor our assessment.**	If yes, where: When: With whom:

HEARING	
Has your child had many ear infections or glue ear (otitis media)? Yes ☐ No ☐	If yes, how frequently?
Has your child had a hearing test? Yes ☐ No ☐	If yes, where? When? Most recent results:

NOSE BREATHING/ADENOIDS/TONSILS/SLEEPING	
Does your child appear to breathe mostly through their nose or mouth?	Nose ☐ Mouth ☐
Does your child snore? Yes ☐ No ☐	If yes, please provide details:

Does your child have a sleep disorder, e.g. sleep apnoea? Yes ☐ No ☐	If yes, please provide details:
Has your child had their adenoids or tonsils removed?	Adenoids: Yes ☐ No ☐ If yes, when? Tonsils: Yes ☐ No ☐ If yes, when?
ORAL BEHAVIOURS	
Did/does your child:	• suck their thumb, fingers or dummies? Yes ☐ No ☐
	• dribble? Yes ☐ No ☐
	• cough after eating or drinking? Yes ☐ No ☐
	• frequently gag on solids? Yes ☐ No ☐.
	If yes to any of the above, please provide details:
VISION	
Has your child had their eyesight tested? Yes ☐ No ☐	If yes, where? When? Most recent results:
DENTAL	
Has your child had their teeth checked? Yes ☐ No ☐	If yes, where? When? Most recent results:
GENERAL MEDICAL HISTORY	
Has your child ever had a convulsion? Yes ☐ No ☐	If yes, when?
Does your child have difficulties with attention, concentration and/or memory? Yes ☐ No ☐	If yes, please describe:
Does your child have difficulties with sensory challenges ie tolerating scratchy clothing, bare feet or sticky hands? Yes ☐ No ☐	If yes, please describe:
Does your child have colds often?	Yes ☐ No ☐
Is your child currently on medication? Yes ☐ No ☐	If yes, what type of medication and for what purpose?
Does your child have any physical disabilities, challenges or impairments? Yes ☐ No ☐	If yes, please describe:
GENERAL PRACTITIONER	
Name of family doctor:	
Address:	Phone:

WHAT ILLNESSES/ACCIDENTS/SURGERIES/HOSPITALISATIONS HAS YOUR CHILD HAD?

Type of illness	Age	Treatment

Were there noticeable changes in your child's speech or communication immediately following any of these events?	Yes ☐ No ☐. If yes, please provide details:

OTHER HEALTH/EDUCATIONAL PROFESSIONALS HELPING YOUR CHILD

Professional	Name	Still seeing	Reason for assistance

Paediatrician		Yes ☐ No ☐	
Occupational Therapist		Yes ☐ No ☐	
Physiotherapist		Yes ☐ No ☐	
Ear, Nose & Throat Specialist		Yes ☐ No ☐	
Psychologist		Yes ☐ No ☐	
Dietician		Yes ☐ No ☐	
Private Tutor		Yes ☐ No ☐	

SCHOOL/PRE SCHOOL/ CHILD CARE ISSUES AND SUPPORT	
Does your child have any issues at school/pre-school/childcare (e.g. with socialising, challenging behaviours, reading, writing or communicating)? Yes ☐ No ☐	If yes, please provide details:
Does your child receive special assistance or support at school/pre-school/childcare? Yes ☐ No ☐	If yes, please describe the support received:

OTHER COMMENTS
Are there any other comments that you would like to make about your child or your concerns/priorities?

PARENT/CARER CONSENT

I confirm the information I have provided in this questionnaire is true and correct to the best of my knowledge.
Yes ☐ No ☐

I give my permission for Let's Talk, Let's Eat to:

- speak with the above-named health/education professionals about your child's development? Yes ☐ No ☐
- make audio voice recordings of your child for the purpose of an assessment? Yes ☐ No ☐
- send reports and/or correspondence to you by email? Yes ☐ No ☐

Name of parent/carer:	Date:
Would you like your child's Assessment Report to be sent to:	• your child's teacher? Yes ☐ No ☐
	• another health professional? Yes ☐ No ☐ Name:

To help us tailor our therapy to your child's interests, please provide us with some information about the types of things your child enjoys doing.

Let's talk Let's eat

SPEECH PATHOLOGY

GETTING TO KNOW YOUR CHILD
What are your child's favourite types of books?
What toys can your child play with independently for a substantial amount of time?
What are your child's favourite computer games/applications and/or internet sites?
What activities does your child like to engage in for long periods of time (e.g. art, hide-and-seek, climbing/jumping, puzzles)?
Does your child have a favourite character (e.g. from television, movies, books)?
What 'real world' objects is your child most interested in (e.g. babies, trees, cars)?
What frightens or intimidates your child (e.g. dogs, loud noises)?
How does your child learn best? Is he/she a quiet observer, active go-getter, someone who needs to 'warm up' to a new task first?
ARE THERE ANY OTHER COMMENTS YOU WOULD LIKE TO MAKE?