BELINDA HILL & Associates
SPEECH-LANGUAGE PATHOLOGY and OCCUPATIONAL THERAPY
Committed to developing communication in a fun, caring and dynamic environment

Practising Members of The Speech Pathology Association of Australia

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

Health Fund Details: Name: **Extras Cover: YES / NO**

Member No:

Are you currently receiving a Centrelink Carer's Allowance? ☐ YES ☐NO

38 Derby Street Kingswood NSW Australia 2747 • Postal address: PO Box 361 Penrith NSW 2751
Phone: **02 4736 8151** • Fax: **02 4736 8171** • Email: mailto:info@therabee.com • Web: www.therabee.com

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** Until what age? _____

Was your baby bottle fed? ☐ **YES** ☐ **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**

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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?

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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:

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:

Is there any other language spoken at home (apart from English)? ☐ **YES** ☐ **NO**

If yes, what language?

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

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