La Trobe Communication Clinic
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Client Information
Preschool Speech and Language Program

PERSONAL DETAILS

Child's Full Name.....

Country of Birth..... **If not born in Australia date of arrival here**.....

FAMILY INFORMATION

Parent/Carer Name	**Parent/Carer Name** .....
Occupation	**Occupation** .....
Country of birth ..... *If not Australia, date of arrival into Australia*	**Country of birth** ..... *If not Australia, date of arrival into Australia* .....
Language(s) spoken	**Language(s) spoken** .....

Names and ages of brothers and sisters of child ....

....

....

Does anyone else live with your family? (e.g. Relative/ friend).....

Name of person to contact about the child .....

REFERRAL INFORMATION

Who referred your child to speech pathology?.....

Referrer position/organisation?.....

What are your concerns about your child's development? .....

.....

.....

.....

SERVICES INVOLVED IN YOUR CHILD'S CARE

Is your child waiting for / receiving any other speech pathology or developmental service(s) e.g. Early Childhood Intervention Services (ECIS), private speech pathology or community health services? If yes please list.

……..

Please provide detail of services where applicable:

Setting	Centre	Name of Teacher	Phone	Days/hours attended
Childcare/Family day care				
3yr old kinder				
4 year old kinder				
4 year old kinder (repeated)				
Other (e.g. school)				

Proposed centre or school for your child next year?……

Please provide details of specialists that your child currently visits or has visited and attach any relevant reports.

Specialist	Name	Agency & contact details	Date last seen	Report available?
Local Dr / or GP				
Paediatrician				
Maternal and Child Health Nurse				
Speech Pathologist				
Other e.g. Occupational Therapist, Psychologist				

DEVELOPMENTAL AND MEDICAL HISTORY

Pregnancy and Birth

Birth Weight …….. **Full term** **Yes** **No** **(please circle)**

Were there any problems associated with your pregnancy or child's birth?

……

Were there any problems immediately after delivery? .....

Did you or the mother experience any difficulties following the birth or in following months? Yes No (please circle)

If yes, did you access any help for this?.....

.....

Is this ongoing? .....

General health

Does your child have any allergies? .....

If yes please describe likely reactions?.....

Does your child have any ongoing medical conditions/diagnoses? .....

.....

Please list any medications your child is currently taking?.....

Has your child had any serious illnesses, accidents, hospitalisations? .....

.....

Has your child's vision been tested? Yes No (please circle)

When ..... **Where** .....

Results of the assessment .....

Has your child's hearing been tested? Yes No (please circle)

When ..... **Where** .....

Results of the assessment .....

Has your child experienced a history of ear, nose or throat infections? .....

.....

Did/Does your child have grommets? Yes No (please circle)

Developmental milestones and current skills

<u>Motor skills</u>

Please indicate the approximate age at which your child achieved the following

Sitting ..... **Standing** ..... **Walking** .....

Please indicate any concerns with gross motor skills such as running, jumping, riding a bike

.....

Please indicate any concerns with fine motor skills such as drawing, writing letters

……

Eating and drinking

Has your child ever had sucking, chewing, swallowing or feeding problems? Yes No

……

Does your child self-feed? Yes No

Is your child a fussy eater? Yes No

Does your child eat a range of food textures, colours, tastes and temperatures? Yes No

If no, please give example of current diet below.

……

……

Toileting/self-care

Is your child toilet trained? Yes No

If yes, at what age were they:

Bladder trained ……Day……Night Bowel trained…….Day……Night

Any concerns or difficulties with toilet training currently or in the past?

……

Sleep

Does your child sleep during the day? Yes No

Does your child need assistance to settle self to sleep at night? Yes No

How many hours of sleep does your child have on average each night?……

SPEECH AND LANGUAGE

Is there any family history of speech, language or learning difficulties? Please describe

……

……

At what age did your child achieve the following communication milestones?

Babbling …….. **Single words** …… **Linked words** ……..

Speech

Do you understand your child's speech? (please circle below)

All of the time Most of the time About half the time Less than 30% of the time

Are there any particular errors/patterns you are aware of? E.g. says k as t, bish for fish

……

……

Language

Do you have concerns about your child's comprehension?
(Does your child follow instructions accurately, answer your questions appropriately, or sometimes misunderstand you?)

……

……

How many words does your child say? E.g. less than 20, more than 50, greater than 200
Please provide a list if less than 50

……

How many words are in your child's sentences? Do they seem well ordered and make sense?

……

……

Do you have to "listen hard" to make sense of what your child is trying to tell you?
Are answers vague/lacking specific words/content?

……

……

Do other people e.g. family members, teachers or peers have difficulty understanding you child?

……

SOCIAL and EMOTIONAL

Do you have any concerns regarding your child's interactions with their peers or family members? Please describe

……

……

What sort of play activities does your child enjoy? Please describe

……

Does your child have any special interests or unusual or repetitive behaviours? Please describe

……

……

Does your child have difficulty regulating their emotions? Please describe

……

……

Is your child under or over sensitive to touch, movement, noises and visual inputs? Please describe

……

……

Have you or anyone else suspected your child may have autism spectrum disorder? Yes No

Is there anything else you would like to add? ……

……

……

……

……

Person completing this form …… **Date**……

Relationship to Child ……

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