



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? <input type="checkbox"/> YES <input type="checkbox"/> NO							

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

Details: _____

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?

Details:

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***