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ASSESSMENT ● TREATMENT ● WORKSHOPS

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Thank you for taking the time to complete and return this form. All information supplied will be treated confidentially and is helpful in ensuring the best treatment for your child.

CLIENT DETAILS:

Surname: ______________________________

First name/s: ______________________________

Age: ________________ Date of Birth: ________________

Grade: ________________ School: ________________

Teacher: ________________ School's contact number: ________________

Home address: ______________________________

______________________________code: ________________

Postal Address: ______________________________

______________________________code: ________________

Home Telephone: ________________ Another contact / emergency: ________________

PAYMENT: PERSON RESPONSIBLE FOR ACCOUNT / MEDICAL AID DETAILS:

Title, Surname, and Initials of Principal Member of Medical Aid / person responsible for account:

____

Name of Medical Aid: ______________________________

Medical Aid Number: ________________ Plan type: ________________

All accounts are emailed unless specified otherwise. Please CLEARLY indicate the email address/es the account should be sent to: ______________________________

____

Parent / Guardian 1 Full Name and Title: ____

Occupation: __________________________ Email address: ____________________________

TEL (W): ___________________ ________ CELL: _________________________________

ID Number: ____

Parent / Legal Guardian 2 Full Name and Title: ____

Occupation: __________________________ Email address: ____________________________

TEL (W): ________________________ CELL: _____________________________________

ID Number: ____

Please mark what is relevant:

Parents are: Married ☐ Divorced ☐

Who does the client live with?

Both Parents ☐ Mom ☐ Dad ☐ Other ☐ ____

WHO REFERRED YOU FOR A SPEECH-LANGUAGE / FEEDING THERAPY ASSESSMENT:

____

PRESENTING PROBLEM / REASON FOR REFERRAL:

____

____

____

THERAPY:

Does your child attend speech-language therapy with any other therapist? Y / N

Has your child had any assessment by a/n: Occupational Therapist ☐ Remedial Therapist ☐

Neurodevelopmental Physiotherapist ☐ Educational Psychologist ☐ Clinical Psychologist / Play Therapist ☐

Other ☐ ____

Names and telephone numbers of therapists or doctors your child sees (e.g.: occupational therapist, physiotherapist, psychologist, specialist doctor): ____

____

PREGNANCY AND BIRTH HISTORY:

Please circle the answer: Was your child adopted? Y / N

Was your pregnancy planned? Y / N

Birth: Normal Delivery ☐ Emergency Caesarean Section ☐ Elective Caesarean Section ☐

Was your child born: Full term ☐ Premature ☐ Post term ☐

If premature, how many weeks? ____

APGAR SCORES ____

Birth weight ________________________Place of birth / hospital: _________________________

Describe the mother's health during pregnancy: Good ☐ Fair ☐ Poor ☐

Were there any problems or complications during **pregnancy**? Please elaborate.

____

____

____

Were there any drugs or alcohol consumed during pregnancy? Y/ N

If yes, please elaborate on what and how often____

____

Were there any complications during or immediately after birth? Y / N

If yes, please elaborate: ____

____

____

____

Was your child **breast-fed**? Y / N

If yes, for how long? ____

Were any feeding difficulties experienced? (e.g.: Non-oral feeding, difficulty latching etc). Please elaborate, if yes.

____

____

____

DEVELOPMENTAL MILESTONES:

Sat at ______________ Crawled at______________ Walked at ____________ First words at _________________

Started putting words together at ____________________________ Toilet trained at _________________________

What kinds of things does your child enjoy doing / playing with?

____

____

____

Is your child a fussy or a messy eater? Y / N Please elaborate, if yes.

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____

Did your child struggle to transition to solid foods, open cup drinking or straw drinking? Please elaborate if yes.

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____

Please tell us about your child's sleeping patterns.

____

____

____

MEDICAL HISTORY:

Has your child's hearing ever been assessed? Y / N

If yes, by whom? ____ Date: ____________________________

Result/ Recommendation: ____

Please provide written results (if available)

Has your child's vision ever been tested? Y/ N

If yes, by whom? ____ Date: ____________________________

Result/ Recommendation: ____

Please provide written results (if available)

Does your child wear: hearing aids ☐ Glasses ☐

Please describe any allergies / medical conditions / chronic medications your child may have.

____

____

____

Has your child ever undergone surgery or had to be hospitalised for any reason (e.g., for grommets, adenoids, trauma, or injury)? ____

____

____

____

____

FAMILY AND HOME:

What is your child's home language? ____

What other languages are spoken in the family / in the home?

____

Is there a discrepancy between your child's ability to understand language and speak?

____

Birth order and names / ages of other siblings: ____

____

____

Is there a family history of any of the following?

Delayed Speech and Language Onset: Relation ______________________________ ☐

Dyslexia / Learning Difficulties: Relation ______________________________ ☐

Congenital Hearing Impairment: Relation ______________________________ ☐

Stuttering: Relation ______________________________ ☐

Autism / Asperger's / PDD: Relation ______________________________ ☐

Remedial schooling or special education: Relation ______________________________ ☐

Other: ______________________________ ☐

What do you see as your child's strengths? ______________________________

____

____

____

How do you foresee this assessment / therapy will help you and your child? ______________________________

____

____

____

Please feel free to use the rest of this page to inform us of any other important information pertinent to the well-being of your child or that you feel may have any impact on their speech / language or overall development, scholastic performance, or social interaction.

____

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Thank you for your time.

Signature: ______________________

Relationship to client: ______________________

Date: ______________________