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CAROL BRENNER
Speech Therapists

ASSESSMENT • TREATMENT • WORKSHOPS

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Thank you for taking the time to complete and return this form. All questions are pertinent in gaining a thorough understanding of the current reason for referral. Please be assured that 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 otherwise specified. Please indicate CLEARLY the email address/es the account should be sent to: _____

_____

Parent / Legal 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 ☐ Separated ☐ Unmarried ☐

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:

Was your child adopted? Y / N

Was the 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 any drugs or alcohol consumed during pregnancy? Y/ N

If yes, please elaborate on what and how frequently _____

_____

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, tongue tie, 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?

_____

_____

_____

Is your child a fussy eater? Y / N Is your child a messy eater? Y/ N Please elaborate, if yes to either of these questions._____

_____

_____

_____

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

_____

_____

_____

_____

Does your child suck a dummy Y / N At what age did they give up the dummy? _____

Does your child drink from a bottle Y / N At what age did they give up the bottle? _____

Does your child such their thumb Y ./ N At what age did they stop? _____

Is your child a mouth breather Y / N / Do not know Does your child snore Yes / No

Please tell us about your child's current sleeping pattern_____

_____

_____

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)

Does your child suffer from recurrent middle ear infections? _____

Has your child had grommets? Y / N Tonsillectomy Y / N Adenoidectomy Y/ N

Please provide further details if Yes. i.e.: how many sets of grommets and ages, when was the most recent set inserted, who is your Child's ENT? _____

_____

_____

Does your child wear hearing aids or have any assistive devices to aid hearing or listening?

_____

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 glasses, and if so, what is the reason for this? _____

Does your child ever complain of headaches Y / N _____

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 other than for grommets, adenoids, or tonsils. Foe example: another medical condition, trauma or injury. _____

_____

_____

_____

FAMILY AND HOME:

What is your child's home language? _____

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

Does you child speak or understand more than one language? Please elaborate _____

_____

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 _____ ☐

ADHD / ADD / Anxiety: relation _____ ☐

Other: _____+_____ ☐

What do you believe to be your child's strengths? _____

_____

_____

_____

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

_____

_____

_____

Please feel free to inform us below 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, and/ or social and emotional interaction _____

_____

_____

_____

_____

Signature: _____

Relationship to client: _____

Date: _____