FREMANTLE SPEECH PATHOLOGY SERVICES

Client Information Profile
Fremantle Speech Pathology Services

The information you provide will help the speech pathologist gain a thorough understanding of your child and enable provision of the most appropriate service and management.

Identifying and Family Information

Child's name:____

Date of birth: ____________________ Current age:______________

Sex: M or F Medicare No: ____________________________

1. Parent/Guardian Name:________________________________

Relationship to child: ________________________________

Residential address: ________________________________

________________________ Post code: ____________________

Phone Home: ____________________ Work: __________________

Mobile: ____________________ Fax:____________________

Email Address: ____

Occupation: ____

2. Parent/Guardian Name: ________________________________

Relationship to child: ________________________________

Residential address: ________________________________

________________________ Post code: ____________________

Phone Home: ____________________ Work: __________________

Mobile: ____________________ Fax:____________________

Email Address: ____

Occupation: ____

Siblings: Name: __________ Date of birth: __________ Age: ______

Name: __________ Date of birth: __________ Age: ______

Name: __________ Date of birth: __________ Age: ______

Name: __________ Date of birth: __________ Age: ______

Who is currently living at home with the child? ____________________

Languages spoken at home: ____________________

If there is a language other than English spoken in the home:

Does the child speak the language? Y N ______________

Does the child understand the language? Y N ______________

Who speaks the language? ____________________

Which language does the child prefer to speak at home? ______________

Speech, Language, Learning and Hearing

What are your concerns about your child's speech, language, learning and/or hearing?

____

____

____

Do any family members (including aunties, uncles, grandparents, cousins, siblings, parents etc) have a history of speech, language, learning or hearing difficulties? If so, please provide details

____

____

____

Do you have any concerns about your child's development/progress in any of the following areas? If yes, please describe your concerns

- Speech (saying sounds) ____________________

____

- Language (using and understanding words and sentences) ______________

____

- Reading ___
- Spelling ___
- Maths ___
- Voice quality ___
- Fluency (stuttering) ___
- Physical skills (gross and/or fine motor) ___

___

- Feeding/ Swallowing ___
- Hearing ___
- Memory ___
- Attention ___
- Behaviour ___
- Social skills ___

Who first noticed your child's speech, language, learning and/or hearing difficulties?

___

When were your child's speech, language, learning and/or hearing difficulties first noticed?

___

Do you think your child is aware of their difficulties/problems? ___

Does your child suffer from any medical conditions or disability? If so, please explain___

___

Has your child ever received an evaluation or therapy from any other medical or allied health service/specialist? If so, please specify and explain further below

	Who	Where	When	Outcome/Management
Paediatrician				
Ear Nose and Throat Specialist				
Audiologist				
Speech Pathologist				
Psychologist				
Counsellor				

Eye Specialist ____________________

Occupational Therapist ____________________

Physiotherapist ____________________

Other ____________________

____

If you have a report from any of these specialists, please attach a copy.

Birth History

Pregnancy was ○ Premature ○ Full term ○ Overdue

Was there anything unusual or any complications during the pregnancy and/or during or after the birth of your child? If yes, please describe ____________________

____

What was the general health of your baby in their first year? ____________________

____

Medical History

Has your child had any of the following? If so, please specify and explain further below

	When	How often (if applicable)	Outcome/Management
Tonsillitis			
Tonsillectomy			
Adenoidectomy			
Ear infections			
Frequent colds/flu			
Ear tubes / grommets			
Cleft lip and/or palate			
Breathing difficulties			
Mouth breathing			
Asthma			

Feeding difficulties (sucking; introduction of solids; chewing; other) ____________________

____

Sleeping difficulties ____________________

Vision problems ______________________________

When | How often (if applicable) | Outcome/Management

Thumb/finger sucking habit ______________________________

Encephalitis ______________________________

Head injury ______________________________

Epilepsy ______________________________

Seizures ______________________________

Any other pertinent injury, illness or surgery

____

Is your child currently taking any medications? If so, please provide details ____________

____

Has your child ever needed to take any medications for a long period in the past? If so, please provide details ______________________________

____

Developmental History

Please specify the approximate age your child achieved the following developmental milestones

Sat alone ______________________________

Babbled (e.g. 'baba', 'gaga') ______________________________

Said first words ______________________________

Walked ______________________________

Put two words together ______________________________

Educational History

Name of Kindy / Pre Primary / School: ______________________________

Address: ______________________________

______________________________ Post code: ____________

Phone: ____________ Fax: ____________

Email: ______________________________

Grade in school: ______________________________

Teacher's name: ______________________________

Teacher's email: ______________________________

Name of support teacher (if applicable): ______________________________

Has your child repeated a grade/level? If so, please specify ______________________

What are your child's strengths and best subjects? ______________________________

____

Is your child having difficulty with any subjects? ______________________________

____

Is your child receiving extra help in any subjects? ______________________________

____

If you have recent school and/or Naplan reports, please attach copies of these.

General Behaviour

Please tick as they apply to your child:

- ○ Friendly
- ○ Confident
- ○ Easy-going
- ○ Talkative
- ○ Nervous
- ○ Shy
- ○ Anxious
- ○ Quiet
- ○ Other ______________________________

Do any of the following apply to your child:

- ○ Seems clumsy
- ○ Walks in an awkward manner
- ○ Frequently throws tantrums
- ○ Aggressive and/or destructive
- ○ Likes to follow a strict routine
- ○ Resistant to contact
- ○ Impulsive
- ○ Has some separation anxiety
- ○ Loses balance easily
- ○ Repeatedly mimics what you say
- ○ Withdraws from social interaction
- ○ Displays some repetitive behaviour
- ○ Avoids making eye contact
- ○ Easy to manage
- ○ Inattentive
- ○ Over-sensitive to sounds and/or surroundings
- ○ Other ______________________________

Does your child have any preferred games, toys or hobbies? ____

____

How does your child like to spend his/her play/free time?____

____

Additional Comments / Other relevant information

Is there any other information you would like to add that might assist us in working with your child?

____

____

____

____

____

Name of health fund: ____

Type of cover: ________________________________ Years of membership: ____________

Date of documentation: ____

Completed by: ____