speechcare
Speech pathologists who care

Client Name:	Date of Birth:	Age:
Names of siblings: 1)	Date of Birth:	Age:
2)	Date of Birth:	Age:

Parents Names:

Account to be made out to:

Mobile phone:	Home phone:	Work phone:

Email address:

Postal address:

State: Post code:

Do you have private health insurance? ☐ Yes ☐ No Name of fund:

How did you hear about us? ☐Google ☐Website ☐ Yellow pages ☐Walk in ☐Family/ Friends

☐GP/ Specialist (name): ☐Other (please specify):

What was the main reason for this referral? (please tick)

☐ Speech/ pronunciation of sounds ☐ Stuttering ☐ Literacy ☐ Voice

☐ Understanding of Language ☐ Use of Language ☐ Other

Family History (please tick)

☐ Speech difficulties ☐ Language difficulties ☐ Reading /Spelling difficulties ☐ Stuttering

If yes to any of the above please give details:

Do you speak a language other than English at home? If yes please specify: ☐ Yes ☐ No

Developmental History

Were there any difficulties during the pregnancy or birth? If yes please specify: ☐ Yes ☐ No

Were there any feeding difficulties during infancy? If yes please specify: ☐ Yes ☐ No

Was your child late to achieve motor milestones (sitting up, crawling, walking etc)? If yes please specify: ☐ Yes ☐ No

Was your child late to achieve language milestones? If yes please specify: ☐ Yes ☐ No

Medical History

Are there any diagnosed illnesses/ disorders? If yes please provide details ☐ Yes ☐ No

Has your child had recurrent middle ear infections? If yes please provide details ☐ Yes ☐ No

Has your child's hearing been tested? If yes please provide details/ dates ☐ Yes ☐ No

Educational History

Please select you child's educational level? ☐Pre-prep ☐Prep ☐Primary ☐Middle ☐High School ☐College

Please provide details of school/ teacher:

Is your child experiencing any difficulties at school? If yes please provide details ☐ Yes ☐ No

Social History

Does your child experience any difficulty relating to other children or adults? If yes please provide details ☐ Yes ☐ No

Previous Intervention

Has your child ever been assessed by a Speech Pathologist or received speech therapy? ☐ Yes ☐ No

If yes please provide details:

Has your child been assessed by a medical or other allied health professional (Psychologist, Physio, OT)? ☐ Yes ☐ No

If yes please provide details:

Consent to share information with other professionals

At times, it is important that information is shared with other relevant professionals such as a GP, a referring specialist or allied health professional. Your consent is required for information to be shared.

I, ______________________ (name), consent to Speechcare providing relevant information to other professionals as required.

Signature: Date:

Acknowledgement

Non-Attendance: A minimum of **24 hours notice** is required for appointment changes or cancellations. **Appointments cancelled or changed with less than 24 hours notice will be charged a $40 fee.** Message bank is available outside office hours for your convenience. **Please do not cancel via SMS**, cancellations must be via phone call as SMS messages are not always reliable.

Signature: Date:

Thank you for taking the time to complete this form.