vocalsaints

Speech-Language Therapy • Te Awhina Mo Reo Tapu

Pre-Assessment Form

Contact Information

Child	First Name	Surname	
Address	No Street	Suburb	City Postcode
	Birthdate	Sex ☐ *M*	☐ *F*
Father	Name		
	Home Phone	Work Phone	Mobile
	Email	Occupation	
Mother	Name		
	Home Phone	Work Phone	Mobile
	Email	Occupation	
Doctor	Name	NHI number	
	Medical Centre/GP Surgery		
Specialist	Name		

How did you find Vocalsaints?

☐ Google ☐ Internet Search ☐ Yellow Pages ☐ Facebook ☐ Puketiro Centre/Child Dev Centre

☐ Referral (By↓)

☐ Client _____ ☐ Centre* _____ ☐ Plunket

☐ Dr _____ ☐ School* _____ ☐ Brochure

☐ Specialist _____ ☐ MOE Special Education ☐ Other (please state) _____

*Do you give us permission to speak with teachers regarding your child if necessary? ☐ Yes ☐ No

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Family Environment

Child lives with:

- ☐ Siblings*
- ☐ Birth parents
- ☐ Adoptive parents
- ☐ Foster parents
- ☐ One parent
- ☐ Parent & step-parent

**Name and age of siblings:*

_____

Is there a language other than English spoken in the home? ☐ Yes ☐ No

If yes, which one(s): _____

Does the child speak the language? ☐ Yes ☐ No

Does the child understand the language? ☐ Yes ☐ No

Who else speaks the language? _____

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

Is there a family history of:

Speech delay or disorder	☐ Yes	☐ No
Language delay or disorder	☐ Yes	☐ No
Learning difficulties / Dyslexia	☐ Yes	☐ No
Intellectual impairment	☐ Yes	☐ No
Hearing impairment / grommets	☐ Yes	☐ No
Stutter	☐ Yes	☐ No
Medical diagnosis, e.g. Down Syndrome, Autism	☐ Yes	☐ No

How many weeks was the pregnancy? _____ Child's birth weight: _____

Was there anything unusual about the pregnancy or birth? ☐ Yes ☐ No

If yes, please describe.

Was the mother sick during the pregnancy? ☐ Yes ☐ No

If yes, please describe.

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Did your child go home with his/her mother from the hospital?' ☐ Yes ☐ No

If your child stayed at the hospital, please describe why and for how long.

Medical History

Does your child have an official medical diagnosis, for example Down Syndrome, Autism, Cerebral Palsy, Dyspraxia, ADHD, Auditory Processing Disorder…? ☐ Yes ☐ No

If yes, please describe.

Has your child had any of the following?

- ☐ adenoidectomy
- ☐ allergies
- ☐ asthma
- ☐ breathing difficulties
- ☐ chicken pox
- ☐ colds
- ☐ sore ears but no infection
- ☐ ear infections
  how often? _____
- ☐ grommets
- ☐ encephalitis
- ☐ flu
- ☐ head injury
- ☐ high fevers
- ☐ measles
- ☐ meningitis
- ☐ scarlet fever
- ☐ seizures
- ☐ sinusitis
- ☐ sleeping difficulties
- ☐ thumb/finger sucking habit
- ☐ tonsillectomy
- ☐ tonsillitis
- ☐ vision problems

Other serious injury/surgery?

Has your child had their B4 School Check? ☐ Yes ☐ No

Were there any concerns indicated? ☐ Yes ☐ No

If yes, please explain.

Is s/he currently (or recently) under a specialist's care? ☐ Yes ☐ No

If yes, with whom and why?

Please list any medications your child takes regularly:

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Developmental History

Please tell the approximate age your child achieved the following developmental milestones:

_____sat alone	_____grasped crayon/pencil
_____babbled (variety of sounds)	_____said first words
_____put two words together	_____spoke in short sentences
_____walked	_____was toilet trained

Did you ever consider your child a "quiet baby"?	☐ Yes	☐ No
Was s/he breast fed?	☐ Yes	☐ No
If so, for how long?		
Did your child have difficulty sucking?	☐ Yes	☐ No
Did your child dribble excessively? Is this continuing now?	☐ Yes	☐ No
Does your child prefer a soft diet?	☐ Yes	☐ No
Does your child have difficulty chewing?	☐ Yes	☐ No
Does your child choke on foods or liquids?	☐ Yes	☐ No

Does your child regularly eat:

- ☐ **Fruit – fresh and/or cooked**
- ☐ **Vegetables – fresh and/or cooked**
- ☐ **Meat or poultry**
- ☐ **Dairy (milk, cheese, yoghurt)**
- ☐ **Crunchy food, e.g. crackers or biscuits**

Fluids your child drinks on a regular basis:

Oral movements: On demand can your child

- ☐ Lick their lips
- ☐ Move their tongue side to side, outside of their mouth
- ☐ Kiss
- ☐ Blow (e.g a candle)
- ☐ Poke tongue out

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Preschool History

(if in preschool)

Name of Centre:

Key Teacher:

Days and times of attendance:

How long has your child been in attendance?

What are his/her interests at the preschool?

School History

(if in school)

Name of school and year in school:

Teacher's name:

Has s/he repeated a year? ☐ Yes ☐ No

If yes, which year?

What are his/her strengths and/or best subjects?

Is s/he having any difficulties with any subjects? ☐ Yes ☐ No

If yes, which?

Is your child receiving help in any subjects? ☐ Yes ☐ No

If yes, which?

Has your child ever participated in Reading Recovery? ☐ Yes ☐ No

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Child's Interests

What are his/her interests at home? (What does s/he enjoy doing?)

Does your child like to:

Look at books	☐ yes often	☐ occasionally	☐ not particularly
Colour in	☐ yes often	☐ occasionally	☐ not particularly
Do crafts (glue etc)	☐ yes often	☐ occasionally	☐ not particularly
Play dress-ups	☐ yes often	☐ occasionally	☐ not particularly
Play board games	☐ yes often	☐ occasionally	☐ not particularly

What are things that particular motivate your child? (e.g. certain toys, activities, food)

Does s/he have any favourite characters (e.g. Spiderman or Dora)

Child's Favourite colour(s):

Does your child socialise with other children? ☐ Yes ☐ No

Does you child vocalise/talk while playing, or is s/he more quiet?

Type(s) of play your child engages in:

- ☐ Functional
- ☐ Constructive
- ☐ Solitary (preference to play by self)
- ☐ Parallel (side by side to another child)
- ☐ Imitative (follows the lead of other children)
- ☐ Cooperative (communicating and playing with toys together with other children)
- ☐ Pretend play
- ☐ Games with rules

Screen time

On average, how much time does your child spend on the following each day:

Computer	(minutes)	(hours)
Watching t.v.	(minutes)	(hours)
Ipad	(minutes)	(hours)
Phone	(minutes)	(hours)

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Current Speech and Language

Pre-Verbal Skills (for children under four years of age):

Does your child:

☐ Give you eye contact when you are talking with them?	☐ Yes	☐ No
☐ Imitate – actions, gestures, sounds, words, phrases	☐ Yes	☐ No
☐ Point (and vocalise)	☐ Yes	☐ No
☐ Follow simple instructions that are out of typical routine	☐ Yes	☐ No

On average, how many words do you think your child can say (note, please include the consistent productions of any words, for example "us" means "blanket", or "bis" or "biscuit" and 'woof' for 'dog')

Does your child use any action words, e.g. 'eat', 'drink', 'jump', 'sleep'?	☐ Yes	☐ No
Does your child combine any words together, such as "hi daddy", "eat apple", "me up"?	☐ Yes	☐ No
Your child will copy words but not use them spontaneously themsevles at a later date?	☐ Yes	☐ No

ALL CHILDREN:

Does your child:

- ☐ repeat sounds, words or phrases over and over (and not for the purpose of gaining your attention)?
- ☐ understand what you are saying, outside of routine-based language?
- ☐ give or point to common objects upon request (e.g. "ball", "cup", "shoe")?
- ☐ follow simple directions (e.g. "shut the door" or "get your shoes")
- ☐ respond correctly to yes/no questions?
- ☐ respond correctly to wh-questions? (who/what/where/when/why)

How does your child currently communicate:

- ☐ body language/ gesture / sign language
- ☐ sounds (e.g. vowels, grunts, animal noises)
- ☐ single words (e.g. "up", "mum")
- ☐ 2 to 4 word sentences*
- ☐ sentences longer than 4 words*
- ☐ other _____

* Please give a couple of examples: _____

_____

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Speech Sounds:

Does your child make a variety of different sounds (please circle the sounds your child makes on a regular basis):

b d g m n p t k/c s z f v h j sh l w y ch r

If your child makes speech sound changes, do you think they are these consistent (e.g. 'cat' is always 'tat', 'gone' is always 'don')?

Does your child have a favoured sound, for example may attempts at different words sound similar, such as "da".

Does your child add a vowel souns to the end of words that finish with a consonant (e.g. "Up" is said "up-pa").

Approximately how much can you understand your child in conversation: % (mother) % (father)

Behavioural characteristics:

- ☐ cooperative
- ☐ attentive
- ☐ willing to try new activities
- ☐ plays alone for reasonable lengths of time
- ☐ separation difficulties
- ☐ easily frustrated/impulsive
- ☐ stubborn
- ☐ difficulties concentrating / focusing
- ☐ difficulties learning new things
- ☐ moves between various activities quickly
- ☐ restless
- ☐ poor eye contact
- ☐ easily distracted/short attention
- ☐ destructive/aggressive
- ☐ withdrawn
- ☐ inappropriate behaviour
- ☐ self-abusive behaviour
- ☐ seems unable to sit still / restless and fidgety
- ☐ difficulties completing tasks on time

Time of Sleep (on average):

Night time from _____pm until _____am.

Day time sleep from _____ until _____.

Average number of hours sleep per 24 hour period:_____

Does your child snore?

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Speech Language Therapy

What are your concerns about your child's speech sounds and/or language skills?

- ☐ Speech clarity (i.e. difficult to understand, sound errors, lisp)
- ☐ Understanding other people
- ☐ Expressive vocabularly
- ☐ Sentence structure (putting words together appropriately in the right order)
- ☐ Use of Grammar (e.g. past tense, plurals)
- ☐ Word retrieval (e.g. delay choosing a word to say, or says a similar word like 'lion' instead of 'tiger')
- ☐ Literacy skills
- ☐ Stutter
- ☐ Voice quality
- ☐ Other Concerns (or additional details):

Has your child ever had speech therapy assessment appointment? ☐ Yes ☐ No

If yes, where and when?

What were you told?

Has your child ever had speech therapy lessons (on-going treatment sessions)? ☐ Yes ☐ No

If yes, when and where?

What was worked on?

Did your child have a NewBorn Hearing Screening test (NBHS)? ☐ Yes ☐ No

Were any repeats or follow-up required? ☐ Yes ☐ No

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Has your child ever had hearing test with an Audiologist?	☐ Yes	☐ No

If yes, when and where?

What were you told?

Has your child ever had any other tests/screens for hearing loss or glue ear?	☐ Yes	☐ No
Has your child ever seen an ENT specialist?	☐ Yes	☐ No
Do you have any concerns about your child's hearing?	☐ Yes	☐ No
Has s/he received any other assessment or therapy (e.g. from a Physotherapist, Psychologist, Occupational Therapist, Audiologist for processing, or SPELD)?	☐ Yes	☐ No

If yes, please describe:

Do you have concerns about any other areas of your child's development, including their behaviour?	☐ Yes	☐ No
Is your child aware of, or frustrated by his/her speech/language difficulties?	☐ Yes	☐ No

What do you see as your child's most difficult communication problem at home?

What do you see as your child's most difficult communication problem at school or centre?

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If You Are Concerned About Stuttering

If you are particularly concerned about a stutter:

Is there a known family history of stuttering? ☐ Yes ☐ No

What age did you first start to notice a stutter:_____

Please provide a description or example of the stutter:

Have you noticed any changes in the stutter since it started ☐ Yes ☐ No

If yes, please describe:

Is the stutter episodic (comes and goes) or continuous (present most of the time the child talks)? ☐ Continuous ☐ Episodic

Is your child aware of their stutter? ☐ Yes ☐ No

What advice have you been given so far?

If You Are Concerned About Voice Quality

If you are particularly concerned about your child's voice quality:

Is there a known family history of voice difficulties? ☐ Yes ☐ No

What age did you first start to notice a change in your child's voice:

What is the main concern about your child's voice?

How would you describe your child's voice: husky, croaky, monotone, crackly…

Does your child get frequent sore throats? ☐ Yes ☐ No

How often does your child loose their voice? ☐ Yes ☐ No

Does your child participate in any activities that facilitate yelling (e.g. sports teams) ☐ Yes ☐ No

Does anyone in the home smoke? ☐ Yes ☐ No

Is your child aware of their voice difficulties? ☐ Yes ☐ No

What advice have you been given so far?

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Appointments

What would you most like to achieve from your assessment appointment?

For example, you may wish to establish therapy goals, gain knowledge of your child's speech/language skills and/or receive guidance to support child's communication development.

What would you most like your child to achieve from any therapy?

For example, speech clarity appropriate to aged peers, stimulation to develop language skills, reduction of stutter.

Are you concerned about your child (speech/language) communication skills prior to starting school? ☐ Yes ☐ No

Your Availability

Days and times that **would** suit for therapy appointments:

- Monday morning afternoon
- Tuesday morning afternoon
- Wednesday morning afternoon
- Thursday morning afternoon
- Friday morning afternoon
- Saturday morning afternoon

Do you have any current commitments or restraints that may impact on regular engagement in therapy?

Additional Comments

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Client Agreement

I agree that qualified Speech-Language Therapists from Vocalsaints can work with and collect personal information for the benefit of service provision where necessary for:

Child's Name: _____ Child's DOB: _____

The information may be collected by or shared with the following people or agencies:

Name / Organisation *Contact Details:*

- ☐ Child's Centre/School: _____
- ☐ GP: _____
- ☐ Audiology: _____
- ☐ Child Development Team: _____
- ☐ _____ _____
- ☐ _____ _____

I understand that, by attending Speech-Language Therapy sessions with Vocalsaints Ltd, I agree to the following:

- *Not* to hold Vocalsaints or its workers liable for my child's progress or lack thereof.
- To make any payments on the day of service, otherwise I will pay any interest incurred in addition to the original fee, including any necessary collection costs.
- To Vocalsaints' Cancellation Policy: In the case of missed appointments or cancellations with less than 24 hours' notice is provided, the original fee is still due unless a doctor's certificate is provided; late payments are also subject to interest accrual.
- To information about my child being used for statistical purposes, provided that the information is used anonymously i.e. in a way that will not identify my child or his/her family.
- That for the purposes of collaboration or client handover, speech therapy sessions with child may be observed by a additional qualified Speech-Language Therapist from time to time, in addition to my primary therapist. The second therapist will be an employee of Vocalsaints.
- That under Principle 3 and 6 of the Privacy Act 1993, the parent/caregiver of the named child can access personal information collected by writing to Vocalsaints. Updated contact details for Vocalsaints will be accessible at all times at www.Vocalsaints.co.nz.

Optional Consent (tick if you give permission):

- ☐ I consent for my child to be photographed and/or video recorded for therapy-related reasons.
- ☐ I consent for my child to be observed in-therapy by a Speech-Language Therapy student from time to time; knowing that sessions will not be disturbed or interrupted by this person.

Name: _____ Signature: _____

Relationship to child: _____ Date: _____