vocalsaints
Speech-Language Therapy
Te Awhina Mo Reo Tapu

Child Information Form

Child Details

Child:	First Name	Surname	
Address:	No. Street	Suburb	City Postcode
	Birthdate Age	Sex ☐ *M*	☐ *F*

Parent/ Caregiver 1:	Name	Relationship to child	
	Home Phone	Work Phone	Mobile
	Email	Occupation	
	Address (if different to child's)		

Parent/ Caregiver 2:	Name	Relationship to child	
	Home Phone	Work Phone	Mobile
	Email	Occupation	
	Address (if different to child's)		

Doctor:	Name	NHI number
	Medical Centre/GP Surgery	
Specialist:	Name	

How did you find Vocalsaints?

☐ Website ☐ Internet Search ☐ Brochure ☐ 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

Child lives with:[names and ages] _____

☐ Siblings [name (age)]
☐ Birth parents ☐ Parent and step-parent
☐ Adoptive parents ☐ Grandparents
☐ Foster parents ☐ Aunty/Uncles
☐ One parent ☐ Other

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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? _____

Do you consider your child to be bi/multi-lingual (i.e. learning and using more than one language)? ☐ Yes ☐ No

Birth and Family History

Is there a family history – immediate or extended family – members 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: _____

Medical History

Has your child had any of the following?

- ☐ adenoidectomy
- ☐ allergies
- ☐ breathing difficulties
- ☐ chicken pox
- ☐ colds
- ☐ 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

Other serious injury/surgery?

Please list any medications your child takes regularly:

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School History

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? _____

Have any Teachers expressed concerned? If so, please describe:

Child's Interests

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

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

Regular (weekly or fortnightly) opportunities include:

Screen Time:

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

Computer	(minutes)	(Hours)
TV	(minutes)	(Hours)
IPad	(minutes)	(Hours)
Phone	(minutes)	(Hours)

Current favourite movies or shows: _____

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Current Speech and Language

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 c/k s z f v h j sh l w y ch r

If your child makes speech sound changes, do you think they are consistent?

e.g. “cat is always “tat”, “gone” is always “don”)? ☐ Yes ☐ No

If yes, please give an example(s):_____

Does your child have a favourite sound, for example may attempt at different words that sound similar, such as “da”.

_____

Approximately how much can you understand your child in conversation: _____ %Caregiver1 _____ %Caregiver2

Time of sleep (on average):

Night time from_____pm until_____am

Day time from_____ until_____

Average number of hours sleep per 24 hour period_____

Does your child snore? Yes / No / Infrequent

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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, mumbling)
- ☐ Understanding what other people say / following directions
- ☐ Expressive vocabulary (number or types of words used)
- ☐ Sentence structure (putting words together appropriately in the right order)
- ☐ Use of grammar (e.g. past tense, plurals, pronouns)
- ☐ Word retrieval (e.g. delay choosing a word to say, or saying a similar word like 'lion' instead of 'tiger')
- ☐ Literacy skills (reading and/or writing)
- ☐ Stutter/Dysfluency and/or excessive verbal hesitancies or faulters in speech
- ☐ Voice quality (e.g. hoarse, husky) or voice volume (e.g. unable to control volume)
- ☐ Rate of speech (e.g. consistently talks too fast and is then difficult to understand.)
- ☐ 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?

Are you currently with or on the waitlist for the Ministry of Education or the Ministry of Health? ☐ Yes ☐ No

Has your child ever had speech therapy lessons? ☐ Yes ☐ No

If yes, when and where?

What was worked on?

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

If yes, please why?_____

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 physiotherapist, psychologist, occupational therapist, 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

Are you currently on a service waitlist? (E.g.: Audiology, ENT, Child Development services, MOE, MOH etc.) ☐ 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: (E.g.: repetition of sounds and words, can't get words out etc.)

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)?

☐ Episodic ☐ Continuous

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

What advice have you been given?

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If You Are Concerned About Voice Quality

If you are particulary 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? (E.g.: Husky, croaky, monotone, crackly etc.)

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

How often does your child lose their voice?

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?

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Appointments

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

For example, the entry point to establish therapy goals, knowledge of child's speech/language skills, guidance to support child's communication development.

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

For example: understandable speech to family and peers, language appropriate to aged peers, stimulation to develop language skills, reduction of stutter, whatever is idetnified as a need from speech-language assessment.

Often therapy involves building carer/parental knowledge as well as direct intevention with a child. Is there a parent/carer who can regularly attend therapy appointments? ☐ Yes ☐ No

Are you concerned about your child's (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 (please note that this day is only available in certain locations)

Do you have any current commitments or restraints that may impact on regular engagement in therapy?
e.g: days/times of other appointments, finanical obligations etc.

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Additional Comments

Name of person who completed the form: _____

Signature: _____ Date:_____

The content of this form is so valuable. Thank you for taking the time to complete it ready for your first appointment. Please email the completed form to enquiries@vocalsaints.co.nz and bring the hard copy to your appointment along with any other specialist or Well-Child information.

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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:

Name: _____ DOB: _____

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

Name / Organisation	*Contact Details:*
_____	_____
_____	_____
_____	_____

I agree (please tick each box):

- ☐ *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 Vocal Saints' Cancellation Policy: if there are missed appointments or cancellations where less than 24 hours' notice is provided the original fee is still due. Late payments are also subject to interest accrual
- ☐ to information about my child being used for statistical purposes, provided that the information is used in a way that will not identify my child or his/her family
- ☐ 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 Vocal Saints. Updated contact details for Vocalsaints will be held at www.Vocalsaints.co.nz.

Optional consent

I give consent for my child to:

- ☐ be photographed and/or video recorded for therapy related reasons
- ☐ be photographed and/or video recorded for Vocalsaints marketing purposes
- ☐ be observed by a Speech-Language Therapy student or person interested in Speech-Language Therapy as a profession from time to time; knowing that sessions will not be disturbed or interrupted by this person
- ☐ have Biblically themed activities or references used in therapy

Name: _____ Signature: _____

Relationship to child: _____ Date: _____