FAMILY QUESTIONNAIRE

Great value is placed on the information you have about your child. Sharing this information will contribute to your child's assessment and the recommendations made. Please complete this form as fully as you can and return it BEFORE to your child's first session.

Please note:

Information contained within this questionnaire is treated as highly confidential and accessed only by the speech and language therapist strictly for the purpose of your child's care.

HOME DETAILS					
Child's name	First name(s)				
	Surname				
Date of Birth	Day		Month		Year
Pronouns					
Names of Parents/ Guardians for correspondence	Title(s)	Initial(s)	Surnames(s)		
Person completing form	Parent		Legal Guardian		Other
Your address (including postcode)					
Contact Details	Home			Work	
	Mobile			E-mail	
Does your child live with both parents at the above address?	Yes	No			

SCHOOL DETAILS			
Name of Child's School			
School Address (including postcode)			
School phone no.			
Name of	Head Teacher	Class Teacher	SENDCo.

Learning is complex and differences often run in families. Have any family members had difficulties with:

Attention/ Concentration	Speaking	Social	Reading	Writing &/or spelling	Co-ordination

What languages are spoken at home?	

EARLY DEVELOPMENT

Were there any problems during pregnancy?	Yes*	No
Was pregnancy full term?	Yes	No*
Was delivery normal?	Yes	No*
*Please give details		
Weight at birth		
Were there problems in the early months?	Yes*	No
Were there problems with sucking or feeding	Yes*	No
*Please give details		

At what age did your child	Sit up	Crawl	Walk
SPEECH, LANGUAGE & COMMUNICATION			
At what age did your child begin to babble?			
At what age did your child start using words?			
At what age did your child start joining words?			
Please describe your child's early interaction and play.			
Please give your view of your child's ATTENTION and LISTENING.			
Please give your view of your child's MEMORY skills.			
Please give your view of your child's UNDERSTANDING.			
Describe your child's ability to EXPRESS THOUGHTS AND IDEAS.			
Please give your view of your child's SPEECH.			
Describe your child's progress with READING, WRITING AND SPELLING.			
Please rate you child's CONFIDENCE when listening and talking with others	Fragile Strong 0 1 2 3 4 5		
Please rate your child's OVERALL COMMUNICATION SKILLS	Considerable difficulties Very effective 0 1 2 3 4 5		

Please tick any strategies your child uses to improve his/her communication.	Indicates does not understand		Requests repetition
	Indicates has forgotten		Requests clarification
	Indicates did not hear		Asks what specific words mean
	Pauses to plan what to say		Describes words s/he cannot "remember"
MEDICAL DETAILS			
Has your child had any significant or recurrent illnesses?			
Please give details of any accidents or hospitalisations.			
Please provide details of any illnesses or conditions that may affect your child's learning or development.			
If you child is on medication please give details.			
Please tick if your child has ever been seen by any of the following	Educational Psychologist	Occupational Therapist	Physiotherapist
	Dietician	Paediatrician	Clinical Psychologist/ Child Psychiatrist
Has your child ever been seen by a speech and language therapist?	Yes	No	
Is your child currently receiving speech and language therapy?	Yes	No	

DIET	
Describe your child's early eating and drinking.	
Is your child on a special diet?	
Are any foods or textures avoided?	

VISION				
When and where was your child's most recent eye test?				
What was the result?				
Is your child known to be colour blind?	Yes	No		
Does your child mention visual difficulties when reading?	*Yes	No	*Please give details	
Has your child seen an optometrist relating to visual discomfort or disturbance?	*Yes	No	*Please give details	
HEARING				
Has your child's hearing been tested? If so please give details.				
Does your child have a history of ear infections?	*Yes	No	*Please give details	
Has your child had surgery for	Tonsils	Adenoids	Grommets	
Have you ever been concerned about your child's hearing?	Yes	No		
Do you think your child hears normally at the moment?	Yes	No		
ACTIVITY/ BEHAVIOUR				
Please tick if your child has ever had particular difficulty with	Climbing stairs	Cycling	Ball skills	Swimming
	Dressing	Using cutlery	Fastenings	Laces
	Drawing	Lego	Jigsaws/ puzzles	Toileting

At what age did your child show preference for one hand?		Which hand?		
Please describe any difficulties your child has with	Concentration			
	Sleeping			
	Getting on with others			
	Anxiety			
	Co-ordination			
	Change and Transitions			
	Organisation and Independence			
Does your child have increased sensitivity to	Sound	Touch	Taste & Smell	Movement
Please describe your child's personality.				
Does your child have any special interests or talents?				
Does your child have any particular dislikes or fears?				
EDUCATIONAL HISTORY				
Names of past nurseries/ schools attended	Dates	Name and Town/City		

Has your child missed a lot of school?	Yes	No	
Reasons, other than age, for changing schools.			
Has your child had extra support IN school?	Yes*	No	
*If yes, please give details.			
Has your child had extra support OUTSIDE school	Yes*	No	
*If yes, please give details.			

YOUR VIEWS	
What is your view of your child's needs?	
What are your main questions?	
What views has your child expressed?	

INFORMATION FROM OTHER PROFESSIONALS AND YOUR CHILD'S SCHOOL

Information from other professionals who have or are currently working with your child ensure assessment and therapy is based on a full understanding of your child. For this reason, it is helpful for any recent, relevant reports to be sent ahead of your child's first session along with a copy of his or her most recent school report.

DATA PROCESSING

Completion and return of this questionnaire is your acknowledgement that you have read, understood and accept my terms and conditions (please refer to www.wordsspeechtherapy.co.uk)

Print Name: Date:

Signed: