# Parent Questionnaire / Registration Form

Dear Parents,
Please take some time to fill in this questionnaire. The information you provide will be most valuable to our clinicians in helping your child with his/her therapy intervention and is strictly confidential.

## Personal Information

Child's Name | Date of Birth | ☐ M ☐ F Sex

Nationality

Mother's Name | Father's Name

Profession | Profession

Handphone | Email Address | Handphone | Email Address

Address

City, Postal Code | Home Phone

## Family and Education Information

Name(s) and Age(s) of Sibling(s)

Language(s) Spoken at Home

Child's Current School | Teacher's Name and Contact Number (if any)

## Referral Information

Main Concerns

Formal Diagnosis (if any)

Who Referred you to our Services?

Name of Therapist(s) or Educational Support Person(s) seen (if any)

TLC Speech & Feeding Clinic

# Developmental Information

## Birth History

**Any Health Problems during Pregnancy/Birth Complications?**

☐ Yes ☐ No

**If yes, please explain**

**Is Your Child a Term Baby?**

☐ Yes ☐ No

**If no, please explain**

**Any Breast/Bottling/Feeding Difficulties?**

☐ Yes ☐ No

**If yes, please explain**

**Is Your Child a Colicky/Hard to Calm Baby?**

☐ Yes ☐ No

**If yes, please explain**

## Medical History

**Any Childhood Illnesses (eg., seizures, ear infections)?**

☐ Yes ☐ No

**If yes, please explain**

**Medications Taken Regularly**

**Primary Physician's Name**

**Allergies/Special Diet Considerations**

## Developmental Milestones

**At what age did your child achieve the following skills?**

| | |
|---|---|
| Sitting Independently | |
| Crawling Independently | |
| Walking Independently | |
| Eating Solid Food | |
| Saying Single Words | |
| Joining Two Words Together | |
| Speaking in Short Sentences | |

## Sensory Motor Development

**Is your child overly or less sensitive to the following stimuli?**

**Visual (eg., sensitive to light, avoids eye contact)**

☐ Yes ☐ No

**If yes, please explain**

**Oral/Gustatory (eg., gags at the sight/smell of food)**

☐ Yes ☐ No

**If yes, please explain**

**Movement (eg., enjoys extreme movements, fears swing)**

☐ Yes ☐ No

**If yes, please explain**

**Sound (eg., notices background noise, fears certain sounds)**

☐ Yes ☐ No

**If yes, please explain**

**Touch (eg., does not like sand, likes soft cushions)**

☐ Yes ☐ No

**If yes, please explain**

## Speech Language Hearing History

**Any Speech/Hearing Problems in the Immediate/Extended Family?**

☐ Yes ☐ No

**If yes, please explain**

**Date of Last Hearing Test done**

**Diagnosis (if any)**

**Does Your Child have Difficulty Following Instructions?**

☐ Yes ☐ No

**If yes, please explain**

**Your Child Currently Communicates Using:**

☐ Body Language

☐ Sounds (eg. vowels, grunts)

☐ Words (eg. shoe, up, dog)

☐ 2-4 Word Sentences

☐ Sentences > 4 Words

☐ Others: _____

## Behaviour and Regulation

**Check if these apply to your child:**

- ☐ Cooperative and Attentive
- ☐ Bowel Movement Problems
- ☐ Sleeping Problems
- ☐ Friendly/Sociable
- ☐ Easily Excitable
- ☐ Easily Distracted
- ☐ Happy
- ☐ Sensitive/Emotional
- ☐ Willing to Try New Activities
- ☐ Difficult to Calm when Upset
- ☐ Prefers to Play Alone
- ☐ Overly Active/Inactive
- ☐ Prefers to Play Alone
- ☐ Others: _____

**Your Child's Favourite Toys and/or Activities**

## Others

**Any other Information that you will like us to know**

**Do you require a Formal Written Report after the Evaluation?**

☐ Yes (Additional Charges Apply) ☐ No

**Thank you for your time!**