



Registration & Pre-Assessment Questionnaire

Child's Name: _____ **Male / Female**

Child's Date of Birth: _____ **Child's Age:** _____

Parent / Guardian Name(s): _____

Home Address: _____

Telephone Number(s): _____

Email Address: _____

Names of People Living in the Home: (please give the ages of other children in the home)

Language(s) spoken in the home: _____

Child's GP:* _____

Name of Surgery & Telephone Number: _____

Child's Paediatrician:* _____

Location & Telephone Number: _____

Child's Nursery or School Name:* _____

Address & Telephone Number: _____

Class / Year Group: _____ **Teacher / Key Worker:** _____



Birth and Medical History

Was your child born premature? Y / N

If yes, what was your child's gestational age at birth? _____

How long did your child remain in the hospital after birth? _____

Did your child require NICU or SCBU care before being discharged home? Y / N

If yes, please give details. _____

Does your child have any medical or developmental diagnoses? Y / N

If yes, please give details. _____

Is your child currently undergoing or on the waiting list for any medical or developmental investigations? Y / N

If yes, please give details _____

Does your child take any medication? Y / N (please list all medication) _____

Has your child had a vision test? Y / N

Date of last vision test: _____ Results of vision test: _____

Has your child had a hearing test? Y / N

Date of last hearing test: _____ Results of hearing test: _____



Has your child previously been seen by a Speech and Language or Feeding Therapist? Y / N
If you are happy to share your child's assessment, please include it with this form.

Name of Therapist:* _____

Location & telephone number: _____

Date of most recent appointment: _____

Findings and recommendations: _____

Is your child on the waiting list for NHS Speech and Language (Feeding) Therapy? Y / N

At what approximate age did your child...

Smile: _____

Sit up: _____

Babble: _____

Crawl: _____

Point to show you something: _____

Walk: _____

Say his/her first word: _____

Wean onto solid foods: _____

Put two words together: _____

Speak in sentences: _____

What does your child like to play with / do at home: _____

Do you have any concerns for your child's communication? Y / N (if yes, please explain)



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Please list your concerns and what you hope to get from our appointment.

Is there anything else you would like to tell me? _____

How did you hear about South Lakes Speech & Language Therapy? _____

☐ **If you would like to receive South Lakes Speech & Language Therapy's email newsletter with information about children's feeding and communication, please tick the box.**

Email address to which you would like the newsletter sent: _____

Please return this form prior to your initial appointment, thank you.

* NB South Lakes Speech & Language Therapy will not make contact with other professionals without your permission.