South Lakes Speech & Language Therapy
southlakesslt.co.uk
SouthLakes.SLT@gmail.com
01539 272034

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: _____

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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 explain _____

_____

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

_____

Does your child have any allergies? Y / N (please list all allergies) _____

_____

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: _____

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

Name of SLT:* _____

SLT location & telephone number: _____

Date of most recent SLT appointment: _____

SLT findings and recommendations: _____

_____

Is your child on the waiting list for NHS Speech and Language Therapy (SLT)? 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: _____

_____

_____

_____

Does your child use a dummy? Y / N

Does your child regularly cough, gag or choke on food or drink? Y / N
What does your child drink from? (please circle all that apply)

Infant Bottle Sippy cup 360 cup Open cup Straw cup Sports bottle

Other: _____

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What foods does your child enjoy eating? (please list) _____

_____

_____

Are there any foods your child refuses or finds difficult to eat? (please list) _____

_____

_____

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

_____

_____

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.