



SPEECH THERAPY FOR KIDS

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Child Questionnaire

PSYCHOLOGICAL SERVICES

Child's Name: (PLEASE UNDERLINE SURNAME) _____ Gender: F / M _____

Date Visited: DD / MM / YYYY _____ Date of Birth: DD / MM / YYYY _____ Age: _____

School: _____ Grade: _____

Language(s) used at home: (IF MORE THAN ONE, PLEASE CIRCLE PRIMARY LANGUAGE) _____

Form completed by: (NAME, RELATION TO CHILD) _____

How did you hear about us?

Friend Recommended School Website Doctor Other: _____

1. GENERAL INFORMATION

Name: _____ FATHER _____ MOTHER _____

Phone: (HOME) _____

Phone: (WORK/MOBILE) _____

Email Address: _____

Please indicate primary contact person with an asterix (*) or list alternate person here:

Name: _____ Phone: _____

Home Address: _____

Other people living at home, apart from parent(s) and child:

NAME	AGE	RELATIONSHIP TO CHILD
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MAIN CAREGIVER(S):

- PARENT(S)
- GRANDPARENTS
- AUNT / UNCLE
- MAID / HELPER

2. HEALTH HISTORY

BIRTH DETAILS

Pregnancy length: (WEEKS) _____ Weight at birth: _____

Birth procedure: (NORMAL, BREECH, CAESAREAN) _____

During pregnancy were there complications / problems? Yes No

During birth and immediately following, did complications occur for child or mother? Yes No

If yes, please describe: (e.g. DIABETES, JAUNDICE, BREATHING PROBLEM, NEED OF INCUBATION, SWALLOWING DIFFICULTIES)

DEVELOPMENTAL MILESTONES If known, at what age did the following occur:

Crawl _____	Day time bladder trained _____
Sit alone _____	Night time bladder trained _____
Walk alone _____	Tie shoelaces _____
First sounds _____	Ascending steps _____
First words _____	Descending steps _____
Use 2-word sentence _____	

Has your child been involved in a major accident/undergone surgery? (INJURIES REQUIRING HOSPITALIZATION)

Yes No Details: _____

Has your child been on or is now taking prescription medication?

Yes No Details: _____

ENGAGEMENT WITH HEALTH ALLIED PROFESSIONALS

Please indicate (tick) past or present involvement with the following health professions:

	PAST	PRESENT	KEY FOCUS & LENGTH OF INVOLVEMENT
Occupational Therapist	<input type="checkbox"/>	<input type="checkbox"/>	_____
Speech Therapist	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurologist	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pediatrician	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychologist	<input type="checkbox"/>	<input type="checkbox"/>	_____

If your child is seeing, or in the past, been seen by medical professionals or therapists, please give name, location, and length of time and for what reason.

Has your child been examined on the following:

If yes, when and results:

- Hearing test
- Eye examination
- Allergy test

Does your child presently have difficulties or problems with the following? (PLEASE TICK)

- | | |
|---------------------------------------|--|
| <input type="checkbox"/> Eating | <input type="checkbox"/> Motion Sickness |
| <input type="checkbox"/> Sleeping | <input type="checkbox"/> High / low intolerance towards pain |
| <input type="checkbox"/> Coordination | <input type="checkbox"/> Independence in daily task |
| <input type="checkbox"/> Vision | <input type="checkbox"/> Unusual fatigue or weakness |
| <input type="checkbox"/> Hearing | <input type="checkbox"/> Others _____ |

If yes to any of the above, please elaborate:

How would you describe your child's present physical health?

How is the child's speech at present? Improving Worsening No Change

Speech problem onset gradually or suddenly?

What are your child's favourite toys and activities?

What does he/she like to eat/drink?

3. BEHAVIOUR AND JUDGEMENT

Does your child have problems with any of the following? (PLEASE TICK)

- | | |
|---|--|
| <input type="checkbox"/> Sensory seeking behaviours | <input type="checkbox"/> Balancing responses |
| <input type="checkbox"/> Clumsiness | <input type="checkbox"/> Manipulation of objects and tools |
| <input type="checkbox"/> Gross Motor Skills | <input type="checkbox"/> Independence in self care tasks |
| <input type="checkbox"/> Oral Motor Issues | <input type="checkbox"/> Performance in physical education |
| <input type="checkbox"/> Sitting still in class | <input type="checkbox"/> Hyperactivity due to sensory seeking behaviours |

(CONTINUED FROM PAGE 3):

- | | |
|---|---|
| <input type="checkbox"/> Short attention span | <input type="checkbox"/> Expressive language |
| <input type="checkbox"/> Fine motor skills | <input type="checkbox"/> Receptive language |
| <input type="checkbox"/> Handwriting | <input type="checkbox"/> Vocabulary (limited) |
| <input type="checkbox"/> Social Skills | <input type="checkbox"/> Pronunciation and articulation |
| <input type="checkbox"/> Speech Delay | <input type="checkbox"/> Communication |

If others, please specify:

4. EDUCATIONAL HISTORY

Did your child attend Kindergarten? Yes No If yes, how many years? _____

Is your child attending or has attended Learning Support Program (LSP) in school? _____

Primary 1: Yes No Primary 2: Yes No

Is your child attending any extra classes outside school? (e.g. TUITION, STUDENT CENTRE)

Yes No If yes, where? _____

5. SOCIAL INTERACTION

How does your child get along with brothers, sisters and/or relatives?

How does your child get along with other children?

How does your child get along with teachers?

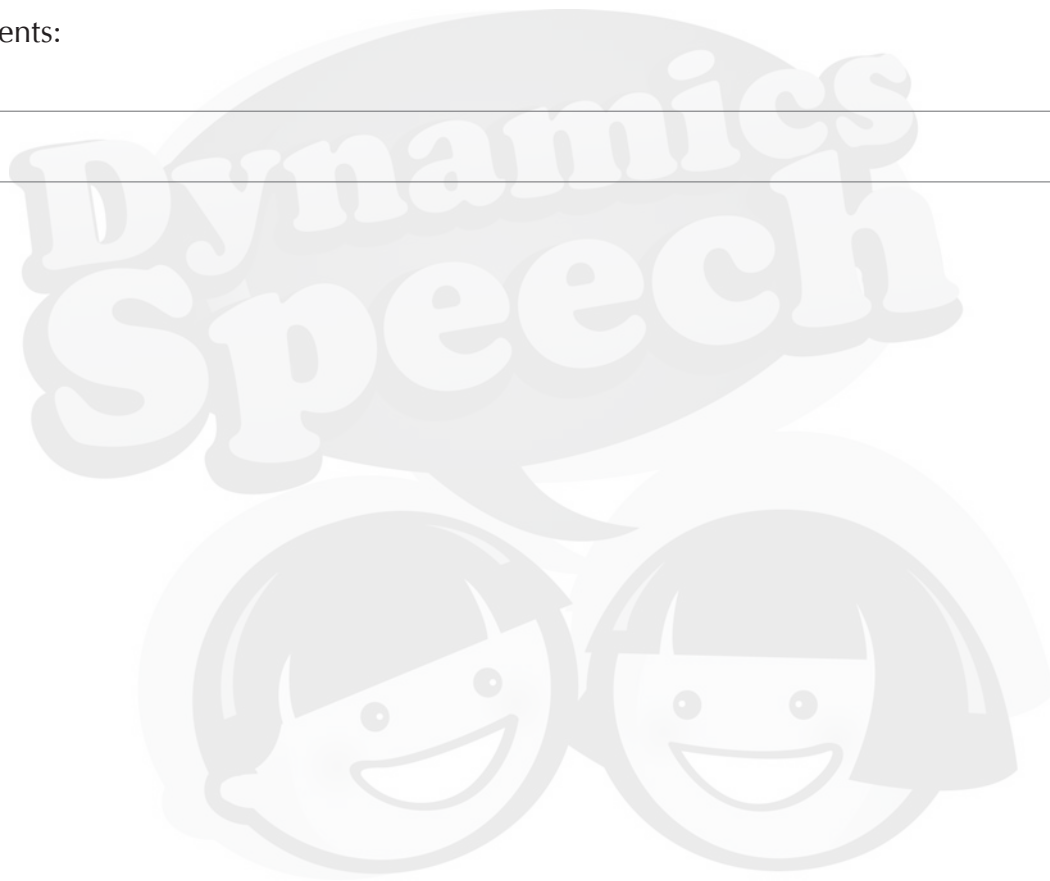
Were there any major stresses your child has experienced? (e.g. DEATH IN THE FAMILY, ILLNESS, DIVORCE, ETC.)

5. PARENT CONCERNS

Please indicate your current concerns:

What do you hope to learn from the assessment?

Other comments:



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