Adelaide Paediatrics

# Adelaide Paediatrics Allied Health

Psychology
Occupational Therapy
Speech Pathology
Physiotherapy
Podiatry
Dietetics
Audiology

## Background Information

It is asked that this questionnaire is **returned at least one week prior** to your child's initial appointment when possible. If there are any problems completing this questionnaire, please contact the reception team at Adelaide Paediatrics either via email, reception@adelaidepaediatrics.com.au or via phone (*please visit our website for the relevant site's phone number*). Thank you.

| | | | |
|---|---|---|---|
| **Child's name:** | | **DOB:** | |
| **Date form completed:** | | **Child's age:** | |
| **Parent/Caregiver:** | | **Phone:** | |
| **Address:** | | | |
| **Childcare/Pre/School:** | | **Year:** | |
| **Referred by:** | | | |

## Personal Information

Is your child under the Guardianship of the Minister? ☐ Yes ☐ No

Does your child identify as Aboriginal or Torres Strait Islander? ☐ Yes ☐ No

Is your child covered under:

☐ NDIA

☐ Mental Health Care Plan / Focused Psychological Strategies (FPS)

☐ Enhanced Primary Care Plan

☐ Private Health Insurance (cannot be used in conjunction with the above)

Does your child have a diagnosed disability? ☐ Yes ☐ No

If yes, please state the diagnosis, date of diagnosis, and the agency/practitioner(s) who diagnosed:

Is your child under the care of a paediatrician? ☐ Yes ☐ No

Name of paediatrician:

## Allied Health Involvement

Is your child currently involved, or had past involvement, in any of the following services:

(If yes, please bring copies of past reports to your interview)

☐ Psychology ☐ Occupational Therapy ☐ Speech Pathology

☐ Physiotherapy / Hydrotherapy ☐ Podiatry ☐ Dietician ☐ Audiology

## Reason for Referral

Why have you chosen to have your child assessed or why have you chosen to seek support from a member of the allied health team?

What are your main concerns (please tick all that apply)?

| | | |
|---|---|---|
| ☐ Giftedness | ☐ Literacy | ☐ Numeracy |
| ☐ General learning | ☐ Behaviour | ☐ Attendance |
| ☐ Social Skills / Play | ☐ Anxiety/Fears | ☐ Attention / Concentration |
| ☐ Low mood | ☐ Auditory processing | ☐ Pain (incl. functional abdominal pain) |
| ☐ Speech | ☐ Use of Language | ☐ Understanding of language |
| ☐ Feeding difficulties | ☐ Sleep | ☐ Toileting |
| ☐ Co-ordination | ☐ Gross motor | ☐ Difficulty walking / unusual gait |
| ☐ Sensory Processing | ☐ Planning / Organisation | ☐ Fine Motor / handwriting |
| ☐ Hearing Difficulties | ☐ Ear Health Issues | ☐ Other |

Please describe the main concerns chosen above and how these impact on your child's daily living?

If behaviour is an issue, what are some of your child's triggers?

Has anyone, such as childcare/preschool/school staff, family or friends, expressed concern about your child's behaviour, social and emotional wellbeing or development? ☐ Yes ☐ No (Please describe)

## Family History

Please name all of the people who live with your child, including siblings and their ages.

| Name | Age | Lives with child(yes/no) |
|---|---|---|
| | | |

What other languages, if any, are spoken with your child?

Is there any family history of:

☐ Mental illness ☐ Attention deficit disorder ☐ Autism spectrum disorder
☐ Sensory processing issues ☐ Speech / Language difficulties ☐ Learning difficulties
☐ Motor difficulties ☐ Arthritis ☐ Dermatology
☐ Neurological issues ☐ Cardiac issues ☐ Genetic concerns

Please list any other medical conditions that run in the family (diagnosed or otherwise)?

## Medical Background

Please describe the health of the mother during pregnancy

Did the mother use alcohol (☐ Yes ☐ No) or smoke (☐ Yes ☐ No) at all during the pregnancy? If yes, please describe the frequency and amount.

Was your child premature or full term? weeks Birth weight

He/she was born via *Choose an item.*

Were there any other complications during or following the birth?

☐ Yes ☐ No If yes, please describe.

Please describe the temperament of your child as a baby (i.e. quiet, attentive, liked to be cuddled, difficult to settle, etc.)

Do you have a strong support system (i.e. close friends, parents/in-laws/other family)?

☐ Yes ☐ No If yes, please describe.

Has your child experienced any significant illness, injury or trauma?

☐ Yes ☐ No If yes, please describe.

Does your child suffer from any allergies?

☐ Yes ☐ No If yes, please describe.

Is your child currently taking any medications?

☐ Yes ☐ No If yes, please describe.

Does your child suffer from ear infections?

☐ Yes ☐ No. If yes, how often?

Did your child see a specialist for their ear problems?

☐ Yes ☐ No Name of specialist:

Has your child had grommets or tubes inserted at any time?

☐ Yes ☐ No If yes, please describe.

Has your child had a hearing test completed?

☐ Yes ☐ No What was the result/outcome of the hearing test?

Has your child had a vision test completed?

☐ Yes ☐ No What was the result/outcome of the vision test?

## Developmental History

How old was your child when he/she first:

- Smiled
- Sit alone
- Crawled
- Walked alone
- Said first words with meaning
- Put two or three words together to make a sentence
- Became toilet trained for daytime hours
- Stayed dry at night

Does your child have any difficulties with coordination or balance? ☐ Yes ☐ No

Would you describe your child as clumsy? ☐ Yes ☐ No ☐ Sometimes

Does your child have any difficulties with fine motor tasks, such as threading, tying shoelaces, cutting or handwriting? ☐ Yes ☐ No

## Feeding History

Is your child gaining weight and following the growth curve (☐ Yes ☐ No)? Who is monitoring this?

Was your child breast (☐ Yes ☐ No) / bottle fed (☐ Yes ☐ No)? How long for?

Were there any issues?

Did your child require artificial/supplementary feeding as a baby?

☐ Yes ☐ No If yes, please describe?

Did/does your child suffer from reflux?

☐ Yes ☐ No If yes, was it treated with medication?

At what age did he/she transition to:

- Breast/bottle to cup
- Puree
- Soft lumps
- Finger foods

Does your child prefer particular textures?

☐ Yes ☐ No If yes, please describe?

## Progress at Pre-school/School

How well is your child progressing at school academically? Are there any concerns?

Does your child currently receive any support at school, kindergarten or childcare?

If yes, *Choose an item.*

Please list current and previous schools/kindergartens/childcare support programmes attended by this child e.g. Reading Recovery, Funtastics, What's the Buzz or similar:

| **Name of Programme** | **Year Level** | **Still participating?** (yes/no) |
|---|---|---|
| | | |
| | | |

If your child is booked for an educational assessment please complete the table below to the best of your knowledge. You may need to request this information from your child's classroom teacher if you are unsure.

| | |
|---|---|
| Current reading level | |
| Number of alphabet letter sounds able to identify | /26 |
| Number of alphabet letter names able to identify | /26 |
| Reading Age and date tested (and test used if known) | |
| Spelling Age and date tested (and test used if known) | |
| Most recent NAPLAN results | |

Are there any particular concerns about your child's social interaction at school?

Do you have any general concerns about your child?

What are you hoping to achieve from today's appointment?

Any other comments?

***Thank you kindly for completing this form to assist with the thorough assessment of your child.***
***Please return this form once completed to reception@adelaidepaediatrics.com.au***
***or fax 08 7123 0821***