MACARTHUR CHILDREN'S DEVELOPMENTAL CLINIC

CLIENT INFORMATION

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For your child's assessment we would like you to fill in this form. This will help us to understand your child and assist with their intervention, which will be provided by a member of our team.
All information you give us about your child is confidential and will not be shown to anyone else without your permission.

We understand that you may not be able to answer all of the questions but please try to give as much detail as you can.

Client Details

Child's First Name: ____________________________ Child's Last Name: ________________________

Date of Birth: _____/_____/_______ Country of Birth: _____________________________

Family Details

Address: ____

____Post Code: ________________________

Phone No: Home: ________________ Work: ________________ Mobile: ______________________

Email Address: ____

Biological Parents: □ Yes □ No Carer: □ Yes □ No

Mother/Carer's Name: _________________________ Father/Carer's Name: ____________________

Mother/Carer's Age: ___________________________ Father/Carer's Age: ______________________

Mother/Carer's Occupation: ___________________ Father/Carer's Occupation: ________________

Relationship Status:____

Parenting Orders (previous or current): ____

Other children in the family:

Name: _____________________________________ Age / Grade: ______________________________

Name: _____________________________________ Age / Grade: ______________________________

Name: _____________________________________ Age / Grade: ______________________________

Name: _____________________________________ Age / Grade: ______________________________

Who lives at home? ____

____

What languages are spoken at home? ____

Family History

Has anyone else in the family (children or adults) ever had: (Please circle yes or no and give details)

- Speech and/or language difficulties? Yes / No ______________________________
- Education/learning difficulties? Yes / No ______________________________
- Physical problems/difficulties? Yes / No ______________________________
- Developmental disability? Yes / No ______________________________
- Emotional problems? Yes / No ______________________________
- Attention problems? Yes / No ______________________________
- Other relevant problems? Please explain____
  ____

History of Pregnancy and Birth

During this pregnancy and birth did the mother and/or baby have any difficulties? If so, please state whether it was the mother or baby and describe: _____________________________________

____

Baby born at: _________________**weeks** Birth Weight: _____________________________________

Did baby require any special treatment after birth? Please describe: ___________________________

____

Developmental Milestones

Speech and Language Development

Please select whether your child did or did not achieve the following and at approximately what age did your child first?

- Babble: □ Yes □ No Age:____
- Use single words (e.g. drink, car): □ Yes □ No Age:____________________
- Put 2 or more words together (e.g. more drink, dad work): □ Yes □ No Age:_____________
- Use longer sentences: □ Yes □ No Age:_____________________________
- Read: □ Yes □ No Age:____
- Count: □ Yes □ No Age:____
- Repeat alphabet: □ Yes □ No Age:_______________________________________

Does your child have any difficulties reading/writing/learning sounds, phonics, blends, rhymes? If so, please provide details:

____
____

Development/Self Help **(Please answer yes or no and give details)**

Please select whether your child did or did not achieve the following and at approximately what age did your child first?

Roll: □ Yes □ No Age:_____________ Sit: □ Yes □ No Age:_______________

Crawl: □ Yes □ No Age:_____________ Walk: □ Yes □ No Age:_____________

Toilet trained: **Day:** □ Yes □ No Age:_____________ **Night:** □ Yes □ No Age:_____________

Dress themselves: □ Yes □ No Bathe themselves: □ Yes □ No

Sleep in their own bed: □ Yes □ No Brush their own teeth: □ Yes □ No

Did/does your child fall or lose balance easily? □ Yes □ No

Did/does your child seem awkward or clumsy? □ Yes □ No

Did/does your child have any unusual habits? □ Yes □ No Please describe: ___________________

____

Eating, Drinking and tool use:

Did your child have feeding problems as a baby? □ Yes □ No If so, Please describe ______________

____

Does/did your child have any eating/drinking problems? □ Yes □ No

If yes, please explain: ____

Is your child a fussy eater? □ Yes □ No

If yes, please explain what they do eat: ____

At approximately what age did your child?

- Start to use utensils (e.g. spoon, fork): _____________________________
- Start to use bottle/sipper cup: ____
- Start to use cup: ____

Medical History

List any illnesses, hospital stays or significant experiences your child has had, and at what age they occurred: ____

____

____

Does your child have a diagnosis? □ Yes □ No If so, please state the diagnosis: _________________

When were they diagnosed?:_______________ Who were they diagnosed by?:_________________

Has your child's **eyesight** been checked? □ Yes □ No If so, When: ___________________________

Results: ____

Has your child's **hearing** been checked? □ Yes □ No If so, When: ___________________________

Results: ____

Has your child had **grommets** inserted? □ Yes □ No If so, When: ___________________________

Results: ____

How often does your child have a cold and/or the flu? (Please circle) Often Sometimes Never

Has your child had any ear infections? Yes / No

How many per year? (Approximately) ____________ When was the last episode? __________________

Treatment (if any): ____

Has your child ever had any convulsions or fits? □ Yes □ No When: ________________________

Is your child on any medication at present? □ Yes □ No Please give details of the medication and purpose: ____

Does your child have any allergies? □ Yes □ No If so, what are they allergic to? ________________

____

Other Professionals

Has your child been seen by or on a waiting list to see any of the following professionals?

Paediatrician	□ Yes □ No	**Special Needs Teacher**	□ Yes □ No
Ear, Nose and Throat Specialist	□ Yes □ No	**Social Worker**	□ Yes □ No
School Counsellor	□ Yes □ No	**Occupational Therapist**	□ Yes □ No
Psychologist	□ Yes □ No	**Speech Pathologist**	□ Yes □ No
Physiotherapist	□ Yes □ No	**Dietician**	□ Yes □ No
Any other specialist or clinic	□ Yes □ No	Please Describe: _______________________________	

Additional Information

Does your child snore? □ Yes □ No

Does your child suck his/her thumb or dummy? □ Yes □ No If yes, Thumb □ or Dummy □

Preschool / School History

Name of preschool/school____

Address: ____

Phone No: _____________________________ Day's Attending: _______________________________

Teacher: ______________________________ Grade: ____

How well does your child interact with others? (Please circle) **Poor** **Reasonable** **Very Well**

Has your child repeated any classes or changed schools? □ Yes □ No Why:______________________

____

Does your child have a support teacher/reading recovery? □ Yes □ No

What is your child's average performance at school? (Please circle) **Poor** **Average** **Consistently Good**

Parent/Carer Concerns

Please describe your concerns about your child ____

____

____

Does your child have difficulty with: (please tick yes or no)

- **Sleeping patterns?** □ Yes □ No **Speech?** □ Yes □ No
- **Concentration?** □ Yes □ No **Language?** □ Yes □ No
- **Following directions?** □ Yes □ No **Literacy?** □ Yes □ No
- **Organising themselves** (e.g. getting ready for school)? □ Yes □ No
- **Behaviour?** □ Yes □ No **Fine Motor?** □ Yes □ No
- **Regulating emotions?** □ Yes □ No **Gross Motor?** □ Yes □ No
- **Social engagment?** □ Yes □ No **Following Routines?** □ Yes □ No
- **Changes in routines?** □ Yes □ No **Play Skills?** □ Yes □ No
- **Handwriting?** □ Yes □ No

How does your child get on with?

- Other children? ____
- Brothers and sisters? ____
- Adults? ____

Childs Strengths

What does your child enjoy doing? ____

____

Please describe your child's motivator's/interests? ___________________________

____

Family Goals for Intervention

What would you like to achieve through intervention:____

____

What are the main goals for your child and family: ____

____

Other

Please provide any additional information which you feel would help us to understand your child better: ____

____

____

The time and effort you have put into completing this form is greatly appreciated and will assist in providing a thorough assessment of your child.

Name of person filling in this form: ____

Date: ____________________ Signature: ____

Office / Professional use only: (please circle yes or no and give details where needed)

- Received signed consent forms to participate in Macarthur Children's Developmental Clinic: Yes/No ____
- Medicare Rebates discussed: Yes/ No ____
- Confidentiality/Consent Forms discussed with parent and child: Yes/No ____