**SPEECH AND LANGUAGE THERAPY PARENT INFORMATION SHEET**

**All information you provide will be kept confidential and filed in your child’s records. Please complete all questions in as much detail as possible.**

**Child’s name:**

**DoB:**

**What name does your child like to be called?**

**Address:**

**Parents’ names:**

**Who has parental responsibility?**

**Phone: (Home)**

**Phone: (Mobile)**

**Phone: (Work)**

**Email:**

**What languages are spoken at home?**

**Name of Nursery/School/College (mainstream or specialist provision):**

**Contact person there if applicable:**

1. **Background**

**Child’s religion (if any):**

**Country of birth/nationality:**

**Ethnicity:**

**Are there any other adults in the household (names and relationship to child)?**

**Name:…………………………………………………..Relationship:…………………………………………….**

**Name:…………………………………………………..Relationship:…………………………………………….**

**Name:…………………………………………………..Relationship:…………………………………………….**

**Does the child have any brothers and sisters?**

**Name:…………………………………DOB:………..**

**Name:…………………………………DOB:…………**

**Name:…………………………………DOB:………….**

**Name:…………………………………DOB:………….**

**Who else is involved in your child’s care (e.g., Paediatrician, Audiologist, Educational Psychologist)?**

**Name:…………………………………………………..Profession:…………………..**

**Name:……………………………………………….....Profession…………………..**

**Name:…………………………………………………..Profession:…………………..**

**Name:…………………………………………………..Profession:…………………..**

**Name:…………………………………………………..Profession:…………………..**

1. **Early History (may not be applicable for teenagers)**

**Were there any difficulties during pregnancy? Yes / No**

**Details:………………………………………………………………………………………………………………………………………………………………………………………….**

**Was your child born early / on time / late? Birthweight: …………………………………………………………………………………………………**

**By how much were they born early or late? …………. weeks …………… days. Due date: ……………….**

**Did your baby suffer any illnesses or require any special treatment immediately after birth or during his/her first weeks? Yes / No**

**Details:………………………………………………………………………………………………………………………………………………………………………………………….**

**Has your child ever had any problems sucking, chewing or swallowing food or drinks? Yes / No**

**Details:………………………………………………………………………………………………………………………………………………………………………………………….**

**When did your child achieve the following milestones?**

**Sitting alone without support………………………………..**

**Crawling:………….……………………………………………………**

**Walking unaided:.………………………………………………….**

**Babbling:……………………………………………………………….**

**Using single words:………………………………………..........**

**Toilet training:.………………………………………………………**

1. **Medical History**

**Has your child suffered any illness / injuries requiring hospitalisation? Yes / No**

**Details (date & nature):…………………………………………………………………………………………………………………………………………………………………………………………..**

**Has your child had any operations? Yes / No**

**Details (date & nature):…………………………………………………………………………………………………………………………………………………………………………………………..**

**Does your child suffer from any of the following?**

**Allergies:…………………………………………………………………………………….**

**Asthma:……………………………………………………………………………………..**

**Epilepsy.…………………………………………………………………………………….**

**Ear infections:…………………………………………………………………………….**

**Continuous coughs/colds:………………………………………………............**

**Other:……………………………………………………………………………………………………………………………………………………………………………………………..**

**Has your child had any serious childhood illnesses (e.g. measles)? Yes / No**

**Details:………………………………………………………………………………………………………………………………………………………………………………………….**

**Does your child take any medication? Yes / No**

**Details (name, dose & what has it been prescribed for?):…………. ………………………………………………………………………………………………….**

**Has your child’s hearing been tested? Yes / No**

**Details (date, by whom & result):…………………………………………….**

**Do you have any concerns about your child’s hearing? Yes / No**

**Details:………………………………………………………………………………………………………………………………………………………………………………………….**

**Has your child’s vision been tested? Yes / No**

**Details (date, by whom & result):……………………………………………… ………………………………………………………………………………………………….**

**Do you have any concerns about your child’s vision? Yes / No**

**Details:………………………………………………………………………………………………………………………………………………………………………………………….**

1. **Impact**

**Why do you want your child to see a Specialist Speech and Language Therapist (SLT)?**

**……………………………………………………………………………………………………**

**……………………………………………………………………………………………………**

**……………………………………………………………………………………………………**

**What would you like help with?**

**……………………………………………………………………………………………………**

**……………………………………………………………………………………………………**

**……………………………………………………………………………………………………**

**Do these difficulties stop or make it difficult for your family to do anything? (e.g. shopping, travel, visiting friends and family, parties, going to dentist, hairdresser, etc.)**

**……………………………………………………………………………………………………**

**……………………………………………………………………………………………………**

**……………………………………………………………………………………………………**

**How is your child progressing at nursery/school? How do their difficulties with communicating affect them at school?**

**……………………………………………………………………………………………………**

**……………………………………………………………………………………………………**

**……………………………………………………………………………………………………**

**What does your child enjoy doing (e.g., play/activities)?**

**……………………………………………………………………………………………………**

**……………………………………………………………………………………………………**

**……………………………………………………………………………………………………**

1. **Communication**

**How often does your child currently receive speech and language therapy? ……………………………………………………………………………………………………**

**Where does your child receive speech and language therapy? (e.g. home, clinic, school)**

**……………………………………………………………………………………………………**

**What is the name of your child’s NHS speech and language therapist? ……………………………………………………………………………………………………**

**How often would you like your child to receive direct speech and language therapy from a specialist?**

**……………………………………………………………………………………………………**

**What are your concerns about your child’s speech and language skills?**

**……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………….…………………………….…………………………………………………………………………………………………..**

**Do you have any other concerns about your child?**

**……………………………………………………………………………………………………**

**……………………………………………………………………………………………………**

**………………………………………………………………………………………………………………………………………………………………………………………………………..**

**Describe your child’s speech and language skills.**

**……………………………………………………………………………………………………**

**……………………………………………………………………………………………………**

**…………………………………………………………………………………………………………………………………………………………………………………………………………**

1. **Environment**

**What have you found that helps your child’s communication?**

**……………………………………………………………………………………………………**

**……………………………………………………………………………………………………**

**……………………………………………………………………………………………………**

**Does your child get any help at nursery/school? If so, what?**

**……………………………………………………………………………………………………**

**……………………………………………………………………………………………………**

1. **Awareness**

**Do you think your child is aware of her/his difficulties?**

**……………………………………………………………………………………………………**

**……………………………………………………………………………………………………**

**……………………………………………………………………………………………………………………….……………………………………………………………………………….**

**What do you think would help your child and family?**

**……………………………………………………………………………………………………**

**……………………………………………………………………………………………………**

**……………………………………………………………………………………………………………………….……………………………………………………………………………….**

**Form completed by:**

**Relationship to the Child:**

**Date:​**

**Signed:**

**Thank you for your time in completing this questionnaire; I will contact you soon to discuss the outcome.**

**Please return form to:**

**Gwendolina Toner**

**Dept. of Speech & Language Therapy**

**Down’s Syndrome Association**

**Langdon Down Centre**

**2a Langdon Park**

**Teddington**

**Middlesex**

**TW11 9PS**

**Tel: 0333 1212 300**

**Email: gwendolina.toner@downs-syndrome.org.uk**