



Appointment Date: _____
 Surname of child: _____
 First Name of child: _____
 Child's DOB: _____ Age: _____
 Sex: Male Female

APD PARENT QUESTIONNAIRE

Child's Surname: _____ Given Names: _____
 Date of birth: ____/____/____ Sex: Male Female
 Parent/Caregiver's Name(s): _____
 Home Address: _____
 Suburb/Town: _____ State: _____ Postcode: _____
 Home Phone: _____ Mobile Phone: _____
 E-mail Address: _____
 Child's School: _____ Grade: _____
 Class Teacher: _____
 Who referred your child for the APD assessment? _____
 What was the reason for the referral? _____

BACKGROUND INFORMATION

Please indicate if your child has a history of any of the below. If 'yes' please describe:

Has your child ever had any significant childhood illness or accidents? Yes No

Has your child had any of the below? If yes, please describe.

Speech/language problems? Yes No _____
 Physical/motor skills problems? Yes No _____
 Ear infections? Yes No _____
 Grommets inserted? Yes No _____
 Hearing difficulties? Yes No _____
 Sleeping difficulties? Yes No _____

How is your child's current health? _____

Has any family member had a speech/language problem or a learning disability? Yes No

Has your child seen any of the professionals below? If yes, please provide the professional's name and reason for appointment.

Speech Pathologist Yes No _____

Audiologist Yes No _____

Psychologist/Counsellor/guidance officer Yes No _____

Physiotherapist Yes No _____

Occupation Therapist Yes No _____

Optometrist Yes No _____

Ear, Nose and Throat (ENT) Specialist Yes No _____

Paediatrician Yes No _____

If you were given any reports from these professionals, please bring them along to the appointment

LISTENING

Is your child easily distracted by noise e.g. television, people talking? Yes No

Does your child have difficulty paying attention? Yes No If yes, please describe.

Does your child avoid listening/talking activities? Yes No If yes, please describe.

Is your child able to communicate better in some situations? Yes No If yes, please describe.

SPEECH AND LANGUAGE

Does your child experience any of the below? If yes, please describe.

Have difficulty following instructions/directions? Yes No _____

Request questions/instructions to be repeated? Yes No _____

Confuse similar words e.g. ship/sheep? Yes No _____

Understand better when spoken to individually? Yes No _____

Follow the storyline when you tell him/her something? Yes No _____

Realise when he/she does not understand someone/something? Yes No _____

Does your child experience any of the below when answering questions? If yes, please describe.

Responds inconsistently? Yes No _____

Responds slowly? Yes No _____

Requires you to speak slowly in order to gain understanding? Yes No _____

Requires you to face them when talking to understand? Yes No _____

Does your child experience any of the below when story telling? If yes, please describe.

Confuses the order of events? Yes No _____

Lacks detail? Yes No _____

Repeats himself/herself? Yes No _____

Has speech that is unclear/difficult to understand? Yes No _____

LEARNING SKILLS/LITERACY

Does your child often reverse letters/words when reading Yes No If yes, please provide an example.

Does your child often reverse letters/words when writing? Yes No If yes, please provide an example.

Does your child dislike reading/writing? Yes No If yes, please describe.

BEHAVIOUR

Please indicate if any of the below describe your child. If yes, please describe.

Is your child disorganised? Yes No _____

Is your child easily distracted? Yes No _____

Does your child day dream or appear 'not with it' at times? Yes No _____

Does your child appear forgetful? Yes No _____

Does your child perform better when shown what to do rather than told? Yes No _____

Is your child always on the go, fidgets or squirms? Yes No _____

Does your child talk excessively? Yes No _____

Does your child have trouble relating to their peers? Yes No _____

Does your child dislike/avoid noise? Yes No _____

Is your child clumsy? Yes No _____

EDUCATION

Please rate how your child performs in the following subjects

	Below Average		Average	Above Average	
Reading	1	2	3	4	5
Maths	1	2	3	4	5
Spelling	1	2	3	4	5
Writing i.e. written expression	1	2	3	4	5
Art	1	2	3	4	5
Music	1	2	3	4	5
Sport	1	2	3	4	5

GENERAL INFORMATION

What does your child enjoy doing?

What are your child's strengths?

What concerns you most about your child?

Do you think your child performs to his/her best ability at school? Yes No If no, please describe.

Do you think your child has concerns about his/her abilities?

Privacy of Information Statement

South Australia Speech and Hearing Centre Pty Ltd collect's sensitive information about your child's health. We would like permission to disclose, exchange and release this information with other health professionals relevant to your child's care. Effective safeguards are in place to manage the handling and storing of this information.

Parent/Guardian: _____ Signed: _____ Date: _____
(PLEASE PRINT)