

Please attach a photo of your child.

Background Information

Date:

Child's Name:	Age: y - mths	Date of Birth:	Sex:
Service Requested: ST <input type="checkbox"/> OT <input type="checkbox"/> PT <input type="checkbox"/>			
Mother's Name:	Father's Name:		
Home Address:	Home Address:		
Home:	Home:		
Work:	Work:		
Mobile:	Mobile:		
email:	email:		
Occupation:	Occupation:		

Referral Information

Who referred you to SPOT?
Please describe your child's issues. Please include any information you feel is relevant:
Has your child been evaluated for any of the issues listed above? If so, by whom and when? What were the findings?

Birth and Infancy Details

Difficulties Following Birth:	Difficulties During Infancy:	
<input type="checkbox"/> Needed Oxygen	<input type="checkbox"/> Sleeping	<input type="checkbox"/> Irritable
<input type="checkbox"/> Needed Incubation	<input type="checkbox"/> Limp	<input type="checkbox"/> Jittery
<input type="checkbox"/> Had Trouble Sucking	<input type="checkbox"/> Rigid	<input type="checkbox"/> Overactive
<input type="checkbox"/> Intubation	<input type="checkbox"/> Colic	<input type="checkbox"/> Under active
Other:	Other:	
Weeks Gestation:	Weight:	APGAR Score:
Length of Hospital Stay:		

Child's Medical History

Childhood Illnesses (please indicate age and frequency)					
<input type="checkbox"/> Ear Infections	Age:	Freq.:	<input type="checkbox"/> Tubes in Ears	Age:	Freq.:
<input type="checkbox"/> Tonsillitis	Age:	Freq.:	<input type="checkbox"/> High Fever	Age:	Freq.:
<input type="checkbox"/> Frequent Colds	Age:	Freq.:	<input type="checkbox"/> Respiratory Infections	Age:	Freq.:
Allergies (please list all):					
Seizures: (Frequency and when was most recent one?)					
Please list and describe any significant injuries, illnesses or major operations along with the dates:					
Has vision been examined? <input type="checkbox"/> Yes <input type="checkbox"/> No			Date:		
Results:					
Has hearing been examined? <input type="checkbox"/> Yes <input type="checkbox"/> No			Date:		
Results:					
Please list any medication your child is taking along with the reason it was prescribed:					

Child's Developmental History

Please Note When Each Occurred:		
Babbled:	Fed Self:	Sat:
Gestured:	Bladder Control:	Crawled:
Spoke first word:	Bowel Control:	Walked:
Put words together:	Dressed self:	Slept through the night:
Was your child bottle fed? Any problems?		
Does your child have any problems with exaggerated gag reflex?		
Did or does your child have any problems eating?		

Child's Educational Details

Name of pre-school:	Grade
Frequency:	Attended since:
Name of school:	Grade/Year Level:
Frequency:	Attended since:

Does your child receive additional support at school? If so, what type, how often and from whom?
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Child's Play and Behaviour Details

How well does your child play with other children?
What are your child's favourite play activities?
Please describe your child's behaviour at home:
Please describe your child's behaviour at school:

Child's Family History

Siblings:	
Name:	Age:
Name:	Age:
Name:	Age:
Name:	Age:
Please list any other people living at home and their relationship to your child:	
Please list all languages spoken at home:	
What is your child's native language?	

Has anyone in the family ever had a history of developmental issues or learning difficulties? If yes, please describe:

Additional Information

If your child requires therapy, what are your personal goals/expectations?

Please note any other information which you consider to be relevant:

Parent's Signature:

Parent's Name (printed):

Date:

Consent Authorisation Form

Consent for therapy

I hereby consent to my child receiving therapy intervention at SPOT as deemed appropriate by the therapists.

Signed:

Consent for shared information

I authorise SPOT therapists to liaise with other professionals who are also involved in my child's education and learning.

Signed:

Please note name(s) and contact details of other therapist(s) and educator(s):

Name	Contact Information

Permission to photograph

I authorise SPOT to photograph my child. I give my consent to allow SPOT to display the photographs in the clinic in public view. These photos will not be purchased and /or duplicated by any other source.

Signed:

No Show and Cancellation Policy

We are working to provide the highest quality treatment and services for children and their families.

In order to provide quality therapy for your child in a timely manner, the following policy has been implemented:

- ✓ If a client is more than 10 minutes late for his/her visit, the appointment will be automatically cancelled. You may request to reschedule the visit for another appointment. If you get stuck in traffic, please call ahead to notify your therapist.
- ✓ If a client misses 25% or more of his/her scheduled appointments, visits will be reduced to 1 visit per month.
- ✓ If the no shows or cancellations continue, the patient will be removed from the schedule.

An excused miss visit includes:

- ✓ 24 hour or more notice of cancellation, prior to scheduled appointment.
- ✓ Notice from doctor, school, etc. stating the reason for the missed visit with date and time.

Any other absences will be considered unexcused and documented as such.

Thank you for choosing SPOT for your speech, physio and occupational therapy services!



If you would like to be kept up to date with the latest news from SPOT, which will include information about workshops and other group activities, please provide your email address below.

Name:	email:
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