

Talking Matters

Speech Pathologists

Helping your child to reach their potential

www.talkingmatters.com.au



TALKING MATTERS- CLIENT INFORMATION

Identifying Information

CHILD'S NAME: _____ Date: _____

DATE OF BIRTH: _____ SPEECH PATHOLOGIST: _____

PRIMARY PARENTS/CAREGIVER

NAMES: _____

ADDRESS: _____

PHONE NUMBER: _____ MOBILE PHONE _____

EMAIL ADDRESS: _____

Are there any custody or restraint orders in relation to this child? If so, please provide details and copies of orders so we can comply as required.

SECONDARY PARENTS/CAREGIVER

****This section is only relevant for families who reside in two separate homes****

NAME/S : _____

ADDRESS: _____

PHONE NUMBER: _____ MOBILE PHONE _____

EMAIL ADDRESS: _____

REFERRAL INFORMATION

NAME OF REFERRING PERSON: _____

GENERAL PRACTITIONERS NAME: _____

GP'S PHONE NUMBER: _____

Has your child been referred for other specialist support services?

Education/School

School/Preschool _____

Year Level _____

Director/Principal: _____

Teacher: _____

What concerns if any has the teacher expressed about your child's communication/learning? _____

What are your concerns regarding your child's communication skills?

HEALTH

Has your child had any major medical issues?

FAMILY

Who lives at home with your child? _____

Is there any family history of speech, language or hearing problems?

What does your child like to do/ play with? _____

How would you describe your child's personality? _____

DEVELOPMENTAL HISTORY

Please describe the health of the mother during pregnancy. _____

Was your child premature or full term? _____ weeks

Was he/she a normal birth/ caesarean/ breech birth? (please circle)

Birth weight _____

Were there any other complications following the birth? _____

Have you seen other health professionals to assist in overcoming the problem?

How old was your child when he/she first:

- Babbled _____
- Crawled _____
- Sat _____
- Said their first word _____
- Started putting words together in a sentence _____
- Walked alone _____
- Fed self with spoon _____
- Toilet trained _____

How old was your child when their communication difficulties were first identified?

Is there anything else you feel is important for us to know?

FEEDING / AND EATING

Has your child ever had difficulty feeding, eating or chewing? _____

HEARING HISTORY

Does your child suffer from ear infections? _____

How often? _____

Did your child see a specialist for their ear problems? _____

Did your child have grommets or tubes inserted at any time? _____

Thank you for completing this profile. Your assistance is appreciated

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CLIENT CONSENT TO EXCHANGE INFORMATION

PLEASE WRITE CLEARLY

In order to arrange support for a child we often need to exchange information with other people involved in the child's care and education. Please tick the boxes to identify other individuals and agencies you are willing for us to exchange information with regarding your child.

I, _____ give consent to Talking Matters to *receive and provide* relevant information regarding my child, _____ with the following: (please ✓ & add name/s)

- Child Care Centre/Kindergarten _____ Phone No: _____
- Speech pathologist: _____ Phone No: _____
- School: _____ Phone No: _____
- Psychologist: _____ Phone No: _____
- Occupational Therapist: _____ Phone No: _____
- Paediatrician: _____ Phone No: _____
- Family doctor: _____ Phone No: _____
- Other _____ Phone No: _____

SPECIAL INSTRUCTIONS: _____

Not all agencies will be necessary for most children. Please list any restriction to contacting or providing information to the people you have agreed to above

I give consent to Talking Matters to send *electronic copies* of written documentation to:

- Myself: Postal Address: _____
Email Address: _____
- Teacher: _____
Email: _____
- Doctor : _____
Email: _____
- Psychologist: _____
Email: _____
- Occupational Therapist : _____
Email: _____
- Other: _____
Email: _____

Do you agree to your child being videoed/audio recorded for the purposes of;

- Assessment?: _____ yes/no
- Talking Matters clinician development?: _____ yes/no

Signed : _____ Date : _____

TERMS & CONDITIONS: Please tick each box to indicate that you have read and agree to the following.

Payment Terms:

- ❖ I agree to **pay in full** all professional fees and sale items charged on the day of each service.

Cancellation Policy:

- ❖ I understand a **Cancellation Fee of \$50 will be charged** in the event of a non-arrival or less than 48 hours notice of cancellation for assessment, or 24 hours notice for therapy appointments.

Responsibility for accounts:

- ❖ I understand I am ultimately responsible for the accounts for services provided to my child. I understand that if debt collection or legal action is required in relation to account payments that I will be responsible for all costs incurred.

Parent/Carer's Name: _____

Signed: _____

Relationship to child: _____ Date: _____