SoundSkills
teaching the brain to hear

CLIENT INFORMATION FORM: CHILD

Name of child: _____ NHI Number: _____

Date of Birth: _____ Age: _____ Ethnicity: _____

Referred by: _____

FAMILY DETAILS

Main carer's name: _____

Mother's name: _____

Mother's address: _____

Email Address: _____ Mobile/Best contact phone: _____

Father's name: _____

Father's address: _____

Email Address: _____ Mobile/Best contact phone: _____

What language(s) does the child speak? _____

What language(s) does the family speak at home? _____

Mother's occupation: _____

Father's occupation: _____

MEDICAL CONTACT INFORMATION

GP (Doctor's) Name: _____ Telephone: _____

GP Clinic Name and Address: _____

Health Insurance Provider (if applicable): _____

SCHOOL INFORMATION

Name of School: _____ Telephone: _____

Address: _____

Teacher's name: _____ Child's School Year: _____

Name and contact details of Special Education Needs Coordinator (SENCO) or Head of Learning Support (please contact the school office if you do not know this information):

Name: _____

Email: _____ Telephone: _____

Please note any learning support your child receives at school (eg Resource teacher, teacher aide):

_____

BACKGROUND INFORMATION

What problems does your child have that have led to requesting an assessment with SoundSkills?

How well does your child manage at school, for example with reading/writing/learning?

Please provide details of any ear infections or other hearing problems your child has had.

Please list anyone else in the family with auditory processing/hearing or learning difficulties.

Please list any other professionals involved with your child.

DEVELOPMENTAL HISTORY

Please note anything we should know about your child's birth, early days and medical history.

Please indicate any developmental/behavioural/psychological problems your child has.

- ◯ Autism Spectrum Disorder
- ◯ ADHD/ADD
- ◯ Developmental Delay
- ◯ Anxiety
- ◯ Specific Learning Disorder
- ◯ Learning Difficulties (eg: Dyslexia, Dyscalculia)
- ◯ Language Disorder
- ◯ Brain Injury

Any other disorders or difficulties:

Please list medications your child takes.

COMMUNICATION SKILLS

Please describe any communication problems your child has, such as difficulty with talking or listening to others.

Please describe how your child manages with friendships and in social settings.

◯ I give consent for SoundSkills to use this information to make referrals where necessary to support my child or myself.

◯ I give consent for SoundSkills to send a copy of the assessment report and recommendations to the person/s who referred us for this assessment.

Person completing this form: _____ Date: _____