Thank you for contacting Talking Point for your Speech Pathology / Orofacial Myology Needs.

THE INITIAL APPOINTMENT will be scheduled for 60-90 minutes, unless otherwise discussed.

FUTURE APPOINTMENTS will be approximately 45 minutes (maximum 1 hour). The number of those appointments vary depending on:

1. The diagnosis
2. The severity of the diagnosis
3. The commitment you are able to make to completing home tasks

COMMITMENT TO THERAPY: For the best therapeutic outcomes, and for your own financial benefit **it is essential that you make 100% commitment to therapy.** If you feel that you are unable to make that commitment at any stage, please discuss it with Joanna and we will talk about your options (this may include putting therapy on hold).

Majority of appointments are held in clinic at:

Arundel

(specific address will be provided in your appointment confirmation email)

However, where appropriate, your sessions will either be conducted at your home, school or via telehealth (using the zoom platform).

ALL FEES are kept up to date on the website: www.talkingpointclinic.com. Fees are expected to be paid at the time of the session.

BLOCKS OF THERAPY: During school holidays, therapy is put on hold and recommences with the school term. Therapy is usually provided in blocks of 7-9 weeks.

Please complete the form below electronically. Save it onto your computer and then email it back to me at least 24 hours before your first appointment.
If you are having any difficulty completing the form, please email Joanna:
talkingpointclinic@gmail.com
or
phone Joanna (0401 886 785)

Please refer to the agreement & consent form for further information including the Cancellation Policy.

General Background History Questionnaire

In this questionnaire, 'client' refers to the person who is presenting for the assessment and treatment. That may mean that 'client' refers to you or your child.

Appointment Date:	**Therapist:**	
Client's Full Name:		
Country of Birth:	Date of Birth: / /	
Address:		
Suburb:	Postcode:	
Home Phone:	Mobile - Parent 1:	Mobile – Parent 2:
Work Phone:		
Email Address:		
Medicare Card No:	Client's Reference Number:	Expiry Date:
First adult on Medicare Card:	Their Reference Number:	Their D.O.B.:
Parent 1's Name:	Age:	
Country of Birth:		
Current Occupation:		
Parent's 2 Name:	Age:	
Country of Birth:		
Occupation:		

Does your child live with both parents?

Are there any legal orders in place for your child? **(If yes, please attach orders)**

How did you find out about Talking Point?

Who suggested you seek Speech Pathology?

Why?

Name of Family Doctor:	Contact No:
Practice Address:	
Suburb:	Postcode:

School/Childcare child attends:

Name of Teacher:	Grade:
Which days do they attend?	
Email address of teacher/school/childcare:	

Other Health Practitioners / Tutors that have been or are currently Involved with the Client:

Name	Profession	Phone Number	Diagnosis Given	Goals Working On / Medications Prescribed

Do you give permission for Talking Point (or the clinicians working for Talking Point) to contact the above health practitioners and / or tutors regarding the client?

If the client has any diagnosis, please describe:

The major concerns regarding the client **(place the number 1 to 5 beside only those that you are concerned about)**

1=Not at all 2 = A little 3 = Somewhat 4 = Quite concerned 5 = Very concerned

Eating / Mealtimes	Motor skills at the same level as peers	Social interaction with adults	Tongue-tie (or other ties)
Keeping clean	Using a variety of words	Social interaction with peers	Teeth positioning - misalignment
Getting dressed	Using clear speech	Poor attention	Stuttering
Toileting	Following directions and / or rules	Hyperactive and / or impulsive behaviour	Memory
Able to access things they need to use e.g. turn taps on, use scissors, pencils, toys, household equipment	Ability to carry out a conversation with others	Swallowing, saliva control and / or tongue thrust	Developing reading and writing skills at the level expected
Responding to change	Pretend play	Turn-taking	Impulsivity and safety
Twirling / pulling hair	Mouthing / eating non-food items	Dummy, thumb/ finger sucking or nail biting	

Other children in the family and difficulties experienced

Name	Age	Grade	Difficulties (please tick)								
			Putting sentences together	Difficulty understanding others	Difficulty following directions	Poor speech sounds	Stuttering	Social Skills	Reading/ Spelling	Hyperactivity / Attention	Motor Movement
			☐	☐	☐	☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐	☐	☐	☐

List any other family members and the types of difficulties they have experienced:

Is there one or more family member affected by the following:

☐ Anxiety	☐ Chronic Illness	☐ Psychiatric Illness
☐ Depression	☐ Eating disorders	☐ Social difficulties
☐ Hyperactivity	☐ Learning difficulties	☐ Hearing Loss

Coping Strategies

What are the support mechanisms and lifestyle measure do you have in place to cope with the difficulties that you experience?

☐ Good number of friends	☐ Support groups	☐ Good nutrition
☐ Connected with extended family	☐ Interests that allow a mental / emotional outlet	☐ Sleep 7-9 hours uninterrupted each night
☐ I have a faith	☐ Good exercise routine (30 minutes of vigorous exercise 3-4 x / week)	☐ I drink plenty of water (2 L / day)
☐ Frequently make time to be restful	☐ I avoid stimulants (e.g. caffeine, high sugar diet)	☐ I don't really have support mechanisms and lifestyle measures in place

Check any that describe you

☐ Feeling stressed	☐ Feeling anxious and worried	☐ Feeling down
☐ Had a major loss recently (e.g. job, loved one, money)	☐ Feel little hope	

Would you like support to cope?

Would you like to know more about services that can support you with coping with your current life circumstances?

☐ Yes please ☐ No thanks

General Health of the Client

1. Does the client have more than 6 colds a year? Yes

2. Does the client snore or have heavy / noisy breathing while sleeping? Always Snores

3. Does the client have an frequently open mouth during the day and / or while sleeping? Please describe

4. Is there a history of ear infections, tonsillitis or lung infections?

5. When was the last time the client had their hearing tested?

6. What were the results of the hearing test?

7. Do you have any concerns about the following behaviour (check appropriate boxes)

Tiredness despite adequate sleep	Currently ☐	Previously ☐
Hyperactivity and / or attention difficulties	Currently ☐	Previously ☐
Anxiety	Currently ☐	Previously ☐
Memory difficulties	Currently ☐	Previously ☐
Social skills	Currently ☐	Previously ☐
Impulsivity	Currently ☐	Previously ☐
Aggression	Currently ☐	Previously ☐
Learning delay	Currently ☐	Previously ☐

8. Has the client had any medical procedures? If yes, describe:

10. Does the client take any medications or supplements. If yes, identify which ones and what they are for:

9. Activity / sleep levels of client:

a) Would the client get adequate amounts^ of physical activity of either moderate intensity* or vigorous intensity* per day?
b) Would the client get at least 3 days where they are engaging in adequate amounts^ of activities of vigorous intensity?
c) How many hours a day does the client watch / use electronic devices (e.g. T.V., tablets, computer, smartphones) etc.
d) Are the devices (including T.V.) switched off when not in use?
e) Are any flat-screen devices (T.V., laptops, tablets, smartphones etc) used in the 3 hours before bed time?

f) What time does the client usually go to sleep AND what time do they usually get up?
g) Does the client take a long time to go to sleep AND / OR wake during the night? (please explain what happens if the answer is yes)

^For children and teens = minimum of 60 minutes / 1 hour per day & for adults = minimum of 30 minutes/day
*Moderate intensity = On a scale of 0 to 10, where sitting is a 0 and the highest level of activity is a 10, moderate-intensity activity is a 5 or 6 with slightly heavier breathing (e.g. walking at moderate pace).
*Vigorous-intensity activity is a level 7 or 8 with a much harder huff and puff (e.g. running)

10. Exposure to Toxins:

Is the client frequently or occasionally exposed to any of the following toxins:

Mould (e.g. old house, on window sills)	Frequently ☐	Occassionally ☐
Lead (e.g. old house paint)		
Farming / gardening chemicals	Frequently ☐	Occassionally ☐
Paint fumes	Frequently ☐	Occassionally ☐
Nicotine smoke	Frequently ☐	Occassionally ☐
Passive smoking from other substances	Frequently ☐	Occassionally ☐
Smoke from a internal fire-place	Frequently ☐	Occassionally ☐
Hairdressing chemicals or similar		
Other:	Frequently ☐	Occassionally ☐

Pregnancy / Birth History

1. Please list any prescribed / non-prescribed drugs / medications or supplements taken during the pregnancy or at birth

2. Please list any complications during the pregnancy and / or birth:

3. Describe any assistance required for delivery (e.g. C-section, forceps etc.)

4. How many weeks gestation was the baby born at?

5. What was the baby's birth-weight?

6. Treatments required after birth:

Feeding / Swallowing History

1. If you breastfed, describe any difficulties:

2. If you bottle-fed, describe any difficulties:

3. Describe if the client has had any history of difficulty with feeding (eating / swallowing) - from birth to now:

4. Has the client ever used a dummy / pacifier?

5. Are they currently using a dummy / pacifier?

6. Is there / has there been any thumb, finger, toe-sucking, nail-biting habits?

7. What foods are currently included in the clients diet? (check appropriate boxes)

Soft foods (puree e.g. yoghurt, avocado)	Never ☐	Rarely ☐	Sometimes ☐	Often ☐
Crunchy foods (e.g. nuts, hard biscuits)	Never ☐	Rarely ☐	Sometimes ☐	Often ☐
Chewy foods (e.g. meat or fruit leathers)	Never ☐	Rarely ☐	Sometimes ☐	Often ☐
Fruits	Never ☐	Rarely ☐	Sometimes ☐	Often ☐
Vegetables (e.g. carrots)	Never ☐	Rarely ☐	Sometimes ☐	Often ☐
Green leafy (e.g. lettuce)	Never ☐	Rarely ☐	Sometimes ☐	Often ☐
Cereals / grains (including bread)	Never ☐	Rarely ☐	Sometimes ☐	Often ☐
Protein: nuts, seeds, beans, peas, eggs, legumes, meat	Never ☐	Rarely ☐	Sometimes ☐	Often ☐
Calcium sources: dairy, non-dairy alternatives	Never ☐	Rarely ☐	Sometimes ☐	Often ☐
Packaged / processed foods	Never ☐	Rarely ☐	Sometimes ☐	Often ☐
Fast foods (e.g. McDonalds)	Never ☐	Rarely ☐	Sometimes ☐	Often ☐
Lollies / chocolates	Never ☐	Rarely ☐	Sometimes ☐	Often ☐
Water	Never ☐	Rarely ☐	Sometimes ☐	Often ☐
Juice (100% juice)	Never ☐	Rarely ☐	Sometimes ☐	Often ☐
Juice (not 100%)	Never ☐	Rarely ☐	Sometimes ☐	Often ☐
Caffeinated / coffee flavoured food or drinks: Coffee, coke, slushies, milk	Never ☐	Rarely ☐	Sometimes ☐	Often ☐
Chocolate flavoured food or drinks	Never ☐	Rarely ☐	Sometimes ☐	Often ☐
Softdrink / other artificially sweetened drinks	Never ☐	Rarely ☐	Sometimes ☐	Often ☐

8. How much fluid does the client consume a day?

☐50ml ☐100ml ☐200ml ☐350ml ☐500ml ☐750ml ☐1 litre ☐1.5 litres ☐2 litres

Motor Development History

1. When did the client sit without support?

2. When did the client crawl?

3. When did the client start walking without support?

4. When did the client start running?

5. Can they kick a ball?

6. Can they throw and catch?

7. Can they skip?

8. How would you rate the posture of the client (place a number beside the positions)

1 = very poor 2 = poor 3 = okay 4 = good 5 = very good

Sitting Standing

9. List any concerns you have with the client's gross motor skills (big movements e.g. running, jumping)

10. List any concerns you have with the client's fine motor skills (hand / finger movements e.g. holding a pencil, undoing buttons)

11. List any concerns you have with planning and organising e.g. sequencing daily activities

12. List any concerns you have with the clients sensory system e.g. aversion or attraction to particular sensations (noises, textures, movements)

Speech & Language History

1. Is there a language other than English spoken at home / elsewhere with the client?

2. Did the client start responding to their name at around 6 months of age or younger?

3. Was the client starting to babble - make noises with speech-like sounds around 9 months of age or earlier?

4. Was the client using 1 or 2 short words e.g. 'mama' between 12 and 18 months?

5. Was the client using 2 word phrases e.g. big dog around 2 years of age?

6. Was the client using longer sentences by 3 years of age?

7. Did the client's language skills regress / did they lose some words?

8. At what age and what happened around the time that their language began regressing (if it did)?

9. Did the client's speech become more clear / easy to understand as they got older?

10. Does the client show interest in reading / writing?

Other concerns:

What things does the client find motivating (e.g. specific toys, foods, stickers)? Please list:

Talking Point Speech Therapy Services is part of a Christian ministry to help families in need achieve whole person health through holistic healthy lifestyles. If you would like to know more about our ministry and how we can support you in achieving optimal health, please indicate by marking this box... ☐

*****IMPORTANT THINGS TO NOTE*****

1. For your initial appointment, please bring any reports previously provided to you by a health practitioner or school / preschool.
2. **Completing and emailing as much of your paperwork as possible back to the practice 24 hours prior to the first appointment will allow more time to undertake assessment of the client.** To do this, save this document, add your answers, save it again and email it back to: talkingpointclinic@gmail.com

Thank you and I look forward to meeting you!

Joanna de Bruyn