Capital Therapy Services

New Client Information Form

Child & Family Information

Child's Name: _____ DOB: _____

Gender *(please circle)*: Male / Female

Address: _____ Postcode: _____

Postal Address *(if different from above)*: _____

Preferred Email: _____

Alternative Email: _____

Mother's Details:

Name: _____

Home Ph: _____

Mobile: _____

Work Ph: _____

Work Days/Times: _____

Occupation: _____

Father's Details:

Name: _____

Home Ph: _____

Mobile: _____

Work Ph: _____

Work Days/Times: _____

Occupation: _____

Parent's Relationship Status *(please circle)*: *Married / Defacto / Separated / Divorced*

Who does your child live with? _____

Sibling's Names: _____ Age: _____

_____ Age: _____

_____ Age: _____

Primarily Language/s Spoken at Home: _____

If your child uses a language other than English, please indicate the language, whether it is spoken and/or understood by your child (a little, well or very well) and outline the situations in which they use this language (eg. home, school, with grandparents etc) below:

_____

_____

Child & Family Information cont.

Please describe your child's behaviour and personality *(eg. stubborn, determined, easy going, etc):*

Please list your child's current interests, hobbies, activities, favourite toys and games:

Does your family have any pets? Yes / No

If yes, please provide details (eg. type of pet & pet's name):

Does (or has) anyone in your family experience(d) speech, language, fluency or learning difficulties that you are aware of*? If yes, please provide details*:

Referral Details

How did you hear about / who referred you to **Capital Therapy Services**?

Friend	GP	Yellow Pages	Internet Search/Google
Family Member	Paediatrician	Childcare/School	Speech Pathology Australia
Teacher	NDIS/NDIA	Advertisement	Other: _____

(Please provide a copy of any referral information provided to you)

Please describe the concerns relating to your child *eg. in relation to **speech** (the sounds in words), **language** (the number of words, structure of sentences, grammar, understanding instructions etc), **literacy** (identifying and manipulating sounds in reading and writing etc), and/or **fluency** (repeating sounds or words, blocking on words, stretching out sounds, stuttering):*

_____

_____

_____

Who has noticed/commented on these concerns? *Eg. family, teacher, childcare worker etc*

_____

Please describe what you would like to achieve through attending speech pathology services:

_____

_____

_____

Are there any other concerns you or anyone else has about other areas of your child's health and/or development? *(please circle) Yes / No*

If yes, please describe: _____

_____

_____

Are you accessing services under the Medicare Chronic Disease Management Program? *Yes / No*

Are you accessing services under the National Disability Insurance Scheme? *Yes / No*
(Please provide a copy of your NDIS Plan)

Are you accessing services through your Private Health Insurance: *Yes / No*

If yes, what fund do you belong to? _____

Education & Care Details

Please complete applicable details:

Playgroup

Name: _____

Teacher Name: _____

Days/Times of Attendance**:** _____

Childcare Centre

Name: _____

Room Name: _____ Room Leader: _____

Centre Director: _____ Days of Attendance: _____

Preschool /School

Name: _____

Year Level: _____ Teacher Name: _____

Principal Name: _____ Days of Attendance: _____

Has your child had any cognitive/IQ testing completed through or for schooling? *Yes / No*

If yes, please provide details: _____

_____

Informal Care

Is your child cared for in any informal capacity (eg. by grandparents) on a regular basis? *Yes /No*

If yes, please provide details: _____

_____

_____

Please describe your child's progress and/or any concerns that have arisen in these setting:

_____

_____

_____

Health & Development Details

GP Name: _____ Practice: _____

Paediatrician *(if applicable)*: _____

Please describe any complications with the pregnancy and/or birth of your child _____

_____

_____

Does your child have a significant history of middle ear infections (eg. more than 3?) *Yes / No*

Has your child had their hearing checked (excluding immediately post birth)? *Yes / No*

If yes, when and by whom? _____

Results: _____

Does your child have any medical conditions, allergies and/or diagnoses? *Yes / No*

If yes, please provide details: _____

_____

Is your child currently taking any medications? *Yes / No*

If yes, please provide details: _____

_____

Has your child seen any of the following health professionals…

		If yes, please describe when and what regarding.
Physiotherapist	*Yes / No*	_____
Occupational Therapist	*Yes / No*	_____
Speech Pathologist	*Yes / No*	_____
Psychologist	*Yes / No*	_____
Ear, Nose & Throat Specialist	*Yes / No*	_____

At what age did your child…

Sit _____ Crawl _____

Walk _____ Use their 1st Word _____

Speak in sentences _____

Health & Development Details cont.

Has your child ever used a dummy? *Yes / No*

If yes, at what age did they stop? (*please indicate if they continue to use a dummy)*

_____

Please describe your child's dummy use (eg. frequency of use/times):

_____

_____

Has your child ever sucked their thumb and/or fingers? *Yes / No*

If yes, at what age did they stop? (*please indicate if they continue to suck their thumb/fingers)*

_____

Please describe your child's thumb/finger sucking behaviour (eg. frequency, triggers etc):

_____

_____

Is your child toilet trained during the day? *Yes/ No*

If yes, at what age were they toilet trained? _____

If your child toilet trained at night? *Yes /No*

If yes, at what age were they toilet trained? _____

Please describe any issues/difficulties with toilet training: _____

_____

_____

_____

Does your child snore and/or breath noisily at night? *Yes / No*

Fees and Payments

All appointment fees must be paid after each appointment.

Capital Therapy Services **ONLY** accepts electronic payments and *does not* charge any transaction fees for EFTPOS, MASTERCARD or VISA. A 1.5% transaction fee will be charged for AMEX and DINERS cards.

Medicare and Private Health Fund rebates can be claimed directly from Capital Therapy Services for relevant clients.

Capital Therapy Services are registered NDIS providers and can directly bill the NDIA for clients under a NDIS Plan. We also accept self-managed and third-party managed NDIS participants.

Cancellation Fees

NDIS participants are required to provide 2 clear business days (48hrs) notice when cancelling appointments, otherwise 90% of the appointment fee will be charged against your NDIS plan.

For Non-NDIS clients: at least 24 hours notice is required for non-emergency cancellations. This allows us time to offer your appointment time to another client. Failure to do so may result in a $50 cancellation fee being charged.

Emergency cancellations are accepted at ANYTIME for illness of a client and/or family member, or other unplanned emergency events. As much notice as possible would be appreciated for emergency cancellations. Please **do not attend** appointments if you or you child is unwell. Exclusion periods outlined by the National Health and Medical Research Council that apply to childcare and schools also apply to attendance at therapy appointment. See www.nhmrc.gov.au for further details.

Your speech pathologist may also be required to alter or cancel appointments, for example if they become sick. We will provide as much notice as we can if an appointment has to be cancelled. Ensuring we have your current contact details enables us to get in touch with you easier in such circumstances.

Information & Confidentiality

All personal information about clients and their family is collected by Capital Therapy Services to enable appropriate assessment and intervention for clients. This information forms part of a clinical health record and will be stored electronically in accordance with all relevant laws. Information may be provided to a referrer (eg. Doctor) or funding body (eg. NDIS) but will not be shared with anyone else without consent.

Reports and other information may be sent via email. Please note that information sent via email will not be encrypted and therefore, does not adhere to privacy policies. Please indicate your consent to email reports below.

Photos & Videos

Photos, videos and/or voice recordings may be taken of your child as part of their assessment and/or therapy. These photos, videos and/or voice recordings will form part of their clinical health record and will be stored electronically in accordance with all relevant laws.

These photos, videos and/or voice recordings may be shared with other speech pathologists at Capital Therapy Services for peer support and development purposes, however, will not be shared with any other person without consent.

Therapy Success

All intervention programs provided by our speech pathologists are individually tailored towards the needs of your child. For our programs to be most effective, we will often provide specific activities and/or strategies for families to practice at home. Your speech pathologist will support you in how to complete your home practice. Effective home practice is key to achieving progress and successful outcomes from speech therapy. Whilst progress can be made by simply attending your appointments, faster outcomes can be obtained and maintained by completing follow up activities at home.

Providing Feedback

If you have any comments, questions or concerns regarding your child's therapy program and/or progress, we encourage you to discuss these with your speech pathologist.

Alternatively if you would like to contact one of the Directors of Capital Therapy Services, you can contact Janelle Joy (Mon/Tue) or Samantha McLintock (Wed/Thu) on (02) 6154 6940 or at janelle.joy@capitaltherapyservices.com.au or samantha.mclintock@capitaltherapyservices.com.au.

Consent

I, _____ *(parent name)* provide consent for my child

_____*(child's name)* to access speech pathology services from Capital Therapy Services. I have read and understand the information outlined in relation to fees, payments, the collection and confidentiality of information and recordings and keys to therapy success.

I do / do not agree (*please circle*) to have reports sent to me via email.

Signed: _____ Date: _____