

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: _____

Parent 1 Details:

Name: _____

Relationship to Child: _____

Home Ph: _____

Mobile: _____

Work Ph: _____

Work Days/Times: _____

Occupation: _____

Parent 2 Details:

Name: _____

Relationship to Child: _____

Home Ph: _____

Mobile: _____

Work Ph: _____

Work Days/Times: _____

Occupation: _____

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

Who does your child live with? _____

Sibling's Names: _____ Age: _____

_____ Age: _____

_____ Age: _____

Does your family have any pets? Yes / No

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



Child & Family Information cont.

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:

Please tell us about any special customs or holidays that are important to you:

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

What do you see as your child's strengths?

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

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 and what we could do that would make the biggest difference to the life of your child:

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 there any friends, family or community members or a wider support team that you would like us to include in your child's supports? *If so, please provide details below:*



Referral Details cont.

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

Are you accessing services under the **National Disability Insurance Scheme (NDIS)**? *Yes / No*

If Yes, are you NDIA Managed, Self-Managed, Third-Party Managed or Not Sure (please circle)

Please provide details of your Key Worker (if you have one): _____

(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 your pregnancy and birth, including Apgar Scores (if known): _____

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 who, when and what regarding.

Physiotherapist Yes / No _____

Occupational Therapist Yes / No _____

Speech Pathologist Yes / No _____

Psychologist Yes / No _____

Ear, Nose & Throat Specialist Yes / No _____

Please provide any further information or reports from these or other providers that you would like to share with us.

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 your 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.

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.



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.

Please do not take any video recordings of your child and/or speech pathologists during sessions without direct consent from the speech pathologist. All videos taken are to be used for private therapeutic purposes only.

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.

Accidents & Incidents

Very rarely people visiting Capital Therapy Services may be involved in an accident or incident, eg. bump to the head, medical emergency. If you or your child is involved in an accident whilst in our office, please ensure you notify your speech pathologist or reception as soon as possible.

As registered NDIS Providers, we must notify the NDIS Commission of any serious incident (such as serious injury, abuse etc) involving a NDIS Participant that has occurred in connection with the NDIS supports and services we deliver.

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: _____