Please attach a photo of your child.

Background Information Date:

Child's Name:	Age: y - mths	Date of Birth:	Gender:
Service Requested: ST ☐ OT ☐ PT ☐ Counselling ☐ SpLD ☐			

Mother's Name:	Father's Name:
Home Address:	Home Address:
Home:	Home:
Work:	Work:
Mobile:	Mobile:
email:	email:
Occupation:	Occupation:

Referral Information

Who referred you to SPOT?
Please describe your child's issues. Please include any information you feel is relevant:
Has your child been evaluated for any of the issues listed above? If so, by whom and when? What were the findings?

Birth and Infancy Details

Please list any difficulties following birth (e.g. needed oxygen, incubation, trouble sucking, intubation, etc.):	
Please list any difficulties during infancy (e.g. sleeping, colic, over/underactivity, limp, jittery, rigid, etc.):	
Type of Birth:	Hospital Stay:
Weeks Gestation:	Weight:

Child's Medical History

Please list any childhood illnesses (such as ear infections, tubes in ears, tonsillitis, frequent colds, high fever, respiratory infections, allergies, seizures etc.) (please indicate age and frequency):	
Please list and describe any significant injuries, illnesses or major operations along with the dates:	
Has vision been examined? ☐ Yes - Date: ☐ No	Results:
Has hearing been examined? ☐ Yes - Date: ☐ No	Results:
Please list any medication your child is taking along with the reason it was prescribed:	

Child's Educational Details

Current school:			Previous schools:
Grade:	Frequency:	Attended since:	
Hand Preference: Right ☐ Left ☐ Swaps ☐			
Does your child receive additional support at school? If so, what type, how often and from whom?			

Child's Family History

Siblings:			
Name:	Age:	Name:	Age:
Name:	Age:	Name:	Age:
Please list any other people living at home and their relationship to your child:			
Please list all languages spoken at home:			
What is your child's native language?			
Family history of individual differences:			

Additional Information

What are your goals/expectations from the assessment?
Please note any other information which you consider to be relevant:

Consent Authorisation Form

SPOT is committed to maintaining the highest standards of professionalism; this includes protecting client confidentiality as well as clear communication with families and external agencies where relevant. Please read the statements below carefully and initial each box to signify your understanding and agreement to the terms.
Please do not hesitate to ask for clarification on any of these points.

	I hereby consent to my child receiving therapy intervention at SPOT as deemed appropriate by the therapy team.
	I authorise SPOT therapists to liaise with other professionals who are also involved in my child's education and learning. (Please complete the table below)
	I authorise SPOT to photograph/video my child for the sole purpose of keeping clinical records
	I have read, understood and agree to adhere to the cancellation policy.
	I understand that SPOT Therapists participate in regular confidential clinical supervision in order to support best practice and continuing professional development. I understand that my child / family case may be presented in supervision within the bounds of confidentiality.
	I have read, understood and signed the informed consent policy.
	I would like to receive the monthly e-newsletter from SPOT.

Please note name(s) and contact details of other therapist(s) and educator(s):

Name	Contact Information
Please attach any previous assessment reports or summaries of input received.	

Parent's Signature:	
Parent's Name (printed):	
Date:	