

# ASD ASSESSMENT CLIENT INFORMATION FORM | QUESTIONNAIRE



**SA PAEDIATRICS  
AND NEWBORNS**

Please EMAIL or FAX the forms back PRIOR to your child's appointment

f (08) 7093 0404 | e [assessments@sapan.health](mailto:assessments@sapan.health)

Client Name \_\_\_\_\_ D.O.B \_\_\_\_\_

Parent Name(s) \_\_\_\_\_

What are the names and ages of your child's siblings?

Residential Address

Postal Address *(if different from residential)*

Home Number \_\_\_\_\_

Mobile Number \_\_\_\_\_

Email \_\_\_\_\_

Emergency Contact (name and number) \_\_\_\_\_

Who is responsible for this account? \_\_\_\_\_

## Referrer Details

Name \_\_\_\_\_

Referral Date \_\_\_\_\_

Phone number \_\_\_\_\_

Medicare Number \_\_\_\_\_

Ref No \_\_\_\_\_ Expiry Date \_\_\_\_\_

I, \_\_\_\_\_ (Parent/Legal Guardian) have read the enclosed information regarding fees and payment. I agree to these terms and conditions and give consent for the clinician to provide services to that person/s listed on the client information form. I understand that if an appointment made is cancelled, with less than 24 hours' notice or not attended, that a 50% cancellation fee will apply. I also understand that appropriate Medicare referrals and rebates do not fall under the responsibilities of the clinicians.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Consultant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**\*If there is family separation and associated court orders please bring a copy of these to your appointment.**

## BACKGROUND INFORMATION FORM

Please describe the concerns you have about your child:

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What do you hope to gain from this appointment?

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What are your child's areas of strength?

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Is there any family history of: (include both paternal and maternal extended families)  
(if yes, please specify relationship, eg. maternal uncle, paternal niece)

Autism Spectrum Disorder                      yes/no                      \_\_\_\_\_

Learning Disorders                                yes/no                      \_\_\_\_\_

Speech/Hearing Delay/Disorders            yes/no                      \_\_\_\_\_

Mental Health Issues/Illness                yes/no                      \_\_\_\_\_  
(e.g. depression, anxiety, bi-polar, alcohol/drug abuse)

## PREGNANCY & BIRTH

Please describe your pregnancy (any medications taken, stressors, complications etc.)

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Please describe the birth of your child (full term, forceps, caesarean section, premature, post natal depression, complications/health)

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## DEVELOPMENTAL MILESTONES

### Motor (age in months)

Sat alone: \_\_\_\_\_

Crawled: \_\_\_\_\_

Walked alone: \_\_\_\_\_

Feeding: (*range of textures, dribbling, choking etc.*)

\_\_\_\_\_

\_\_\_\_\_

### Self-Help Skills

Sleeping: (*bed time routine, own bed etc.*)

\_\_\_\_\_

\_\_\_\_\_

Feeding skills: (*use of utensils*)

\_\_\_\_\_

\_\_\_\_\_

Dressing skills: \_\_\_\_\_

Toilet training: \_\_\_\_\_

(*day, night*)

### Communication (age in months)

Babbled: \_\_\_\_\_

Spoke first word: \_\_\_\_\_

Pairing two words together: \_\_\_\_\_

Sentences: \_\_\_\_\_

Family history of communication/learning difficulties:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## MEDICAL HISTORY

Illnesses/conditions: (*ear infections, seizures, allergies, etc.*)

\_\_\_\_\_

\_\_\_\_\_

Any concerns with sleeping/feeding etc.

\_\_\_\_\_

\_\_\_\_\_

Injuries/accidents:

\_\_\_\_\_

\_\_\_\_\_

Operations/hospitalisations:

\_\_\_\_\_

\_\_\_\_\_

Past/current medications:

\_\_\_\_\_

\_\_\_\_\_

Hearing &/or vision checks: (*by whom & when*)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**OTHER AGENCIES/SPECIALISTS**

Has your child engaged in any past or current therapies? Please provide details of whom and duration of sessions (Speech, Psychology, O.T, Physio, counsellor, CAMHS)

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Has your child undergone any previous assessments? *Please provide details. If you have any previous reports please bring these to your appointment.*

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**EDUCATION**

Did your child attend Kindergarten or Child Care? If so, please provide details of any feedback you received regarding their social skills, play skills, communication and behaviour.

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Does your child attend school?

Name of School: \_\_\_\_\_ Year Level: \_\_\_\_\_

Teacher: \_\_\_\_\_

Please provide details of any feedback you received regarding their social skills and peer relationships, academic skills and behaviour.

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**ADDITIONAL INFORMATION**

Please list any significant life events in your child's life (e.g. domestic violence, abuse/neglect, divorce/separation)

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Are there any issues you do not want discussed in front of your child?

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