

# CLIENT INFORMATION FORM & QUESTIONNAIRE | ASD & ADHD ASSESSMENT



**SA PAEDIATRICS  
AND NEWBORNS**

Please TYPE information on form  
and return completed forms TWO WEEKS PRIOR to child's appointment

email: [assessments@sapan.health](mailto:assessments@sapan.health)

## Child Details

Name: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Current age: \_\_\_\_\_ Gender: \_\_\_\_\_

## Respondent Details

Name (person completing form): \_\_\_\_\_

Relationship to child: \_\_\_\_\_ Date questionnaire was completed: \_\_\_\_\_

Mobile Number: \_\_\_\_\_ Email address: \_\_\_\_\_

Residential address: \_\_\_\_\_

Postal Address (if different from residential): \_\_\_\_\_

## Parent Details

Parent names: Parent 1: \_\_\_\_\_ Parent 2: \_\_\_\_\_

Parent occupation: Parent 1: \_\_\_\_\_ Parent 2: \_\_\_\_\_

Are parents Australian Citizens: Parent 1: Yes/No (please circle) Parent 2: Yes/No (please circle)

## Referrer Details

Name \_\_\_\_\_

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

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

## Consent

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.

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

SAPAN Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**\*If there is family separation and associated court orders please forward prior to appointment.**

## BACKGROUND INFORMATION FORM

Please describe your main concerns about your child and what you hope to gain from this appointment:

---

---

---

---

What are your child's areas of strength?

---

---

---

### Family Demographics

Cultural background: \_\_\_\_\_

Languages spoken at home: \_\_\_\_\_

Who does your child live with? Are there shared care arrangements?

---

---

How many siblings does your child have? Ages of siblings:

---

---

---

### Family History

Is there any family history of: (include both paternal and maternal extended families and *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.)

---

---

---

---

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

---

---

---

---

## DEVELOPMENTAL MILESTONES

### Motor (age in months)

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

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

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

### Communication (age in months)

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

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

Spoke in sentences: \_\_\_\_\_

### Feeding and Sleep

Describe your child's feeding habits and dietary concerns: (*range of textures, dribbling, choking etc.*)

---

---

---

Describe any current or previous sleep difficulties: (*bed time routine, own bed etc.*)

---

---

---

---

### Dressing and Toileting

Is your child independent in dressing/undressing? If not, how much assistance is required?

---

---

---

Is your child independent with toileting? When was your child toilet trained (daytime/nighttime)?

---

---

---

## MEDICAL HISTORY

Has your child's hearing been assessed? What was the outcome? Does your child wear hearing aids?

\_\_\_\_\_

Has your child's vision been assessed? What was the outcome? Does your child wear glasses?

\_\_\_\_\_

Describe any previous or current illnesses, injuries, or hospitalisations:

\_\_\_\_\_

\_\_\_\_\_

Has your child been diagnosed with any medical conditions or disorders? (e.g. epilepsy):

\_\_\_\_\_

\_\_\_\_\_

## 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)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## EDUCATION

Does your child attend school? Yes/No

Name of School: \_\_\_\_\_

Year Level: \_\_\_\_\_

Any difficulties experienced (e.g. bullying, social issues): \_\_\_\_\_

\_\_\_\_\_

Previous Schools/Preschools and years attended:

\_\_\_\_\_

\_\_\_\_\_

Reasons for leaving previous schools: \_\_\_\_\_

\_\_\_\_\_

**ADDITIONAL INFORMATION**

**Strengths:**

What are your child's strengths and preferred activities?

---

---

Describe any areas of strength or difficulty in academic skills and any support or intervention received at school:

---

---

---

Describe your child's social skills (e.g., solitary, parallel, cooperative, friendship group):

---

---

---

Please comment on the following aspects of social interaction:

Eye contact: \_\_\_\_\_

Ability to enter another child's play: \_\_\_\_\_

Sharing, waiting, turn-taking: \_\_\_\_\_

Conflict resolution: \_\_\_\_\_

Use of language to express wants/needs: \_\_\_\_\_

Imaginary play: \_\_\_\_\_

Ability to sustain or return to a play theme: \_\_\_\_\_

Please describe any significant life events, traumas, or changes experienced by your child:

---

---

---

Are there any child custody orders, intervention orders, or custody issues relating to your child? (Please attach if yes)

---

---

Is there any information you do not wish to be discussed in front of your child or to be included in the report?

---

---

---

---