Futures Wellness

Speech Pathology New Patient Form

General Information

Title: _____ Surname: _____ First Name: _____

Address: _____ Postcode:_____

Phone (H): _____ (W): _____ (M): _____

E-mail address: _____

Date of Birth: _____ / _____ / _____ Occupation: _____

Emergency Contact: _____ Phone:_____

Medicare Card No: _____ Ref No: _____ Exp:_____

Referred by (please circle): Patient / Medical Practitioner / Google / Social Media / Website / Walk-in / Drive-by

Details:_____

Do you have private health insurance? Yes / No

Health Fund: _____ Health Fund No: _____

If Patient is under the age of 18, please nominate Head of Family Member:

Title: _____ Surname: _____ First Name: _____

Phone (H): _____ (W): _____ (M): _____

Date of Birth: _____ / _____ / _____ Medicare Card No: _____ IRN: ____ Exp: _____

Medical Information

Name of GP: _____ Practice Name: _____

Address: _____ Phone: _____

Are you currently seeing a medical specialist? Yes / No If yes, name: _____

Are you currently seeing any other health professionals? (Please list relevant details)

_____

Living Situation

Who does your child live with? (Check all that apply)

This is important because some speech and language issues have been linked to heredity

- ☐ Birth Parent(s)
- ☐ Adoptive Parent(s)
- ☐ Foster Parent(s)
- ☐ Grandparent(s)
- ☐ Both Parents
- ☐ Mother Only
- ☐ Father Only
- ☐ Other (Please Explain)

_____

_____

Names of Parents or Caregivers?

Name**:** _____ Relationship**:**_____

Name: _____ Relationship**:**_____

Does the child have any siblings?

Name: _____ Sex:_____ Age _____

Hearing/speech/development problems:_____

Name: _____ Sex:_____ Age _____

Hearing/speech/development problems:_____

Name: _____ Sex:_____ Age _____

Hearing/speech/development problems:_____

Languages Spoken

Is there another language(s) other than English spoken at home? ☐ Yes ☐ No Which? _____

Who speaks the other language in the home? (check all that apply)

☐ Mum ☐ Dad ☐ Siblings ☐ Uncles/Aunts ☐ Grandparents

Does the child speak another language? ☐ Yes ☐ No

Does the child understand the other language? ☐ Yes ☐ No

Relevant Medical History

Please indicate the child's birth history

Was there anything unusual about the pregnancy or birth of your child? ☐ Yes ☐ No

If yes, please explain. include 1) how long the pregnancy was in weeks 2) the birth weight of child 3) if the child stayed at the hospital and long the stay was and 4) any developmental issues

_____
_____
_____
_____
_____

Has your child had any of the following: (Check all that apply)

- ☐ Adenoidectomy
- ☐ Allergies
- ☐ Asthma
- ☐ Breathing difficulties
- ☐ Feeding/ swallowing difficulties
- ☐ Frequent colds
- ☐ Ear infections
- ☐ Mumps
- ☐ Scarlet fever
- ☐ Encephalitis
- ☐ Head Injury
- ☐ High Fever
- ☐ Measles
- ☐ Meningitis
- ☐ Flu
- ☐ Vision Problems
  Explain_____
  _____
- ☐ Tongue tie
  Surgery? Y or N
  If Y, When? _____
  Where? _____
- ☐ Seizures
- ☐ Sinusitis
- ☐ Sleeping difficulties
- ☐ Thumb sucking
- ☐ Tonsillitis
- ☐ Tonsillectomy
- ☐ Ear tubes
  When? _____
  Dr? _____
- ☐ Other serious injury or surgeries. (Please explain on the back)

Is your child currently taking any medication? ☐ Yes ☐ No

Please indicate the medications taken and the reason for it.

_____
_____
_____

Development History

Please provide a history of development milestones achieved and the approximate age of your child

_____ Crawl
_____ Sat up alone
_____ Stood up alone
_____ Walked
_____ Babbled
_____ Single words
_____ Combined words
_____ Spoke in sentences
_____ Fed him or herself
_____ Dressed him or herself
_____ Toilet Trained

Does your child do any of the following: (Check all that apply)

☐ Choke on liquids
☐ Choke on food
☐ Avoid certain food (picky eater)
☐ Put objects in his or her mouth
☐ Maintain a special diet

Speech Language and Hearing History

Do you think that your child has a speech or language problem? ☐ Yes ☐ No

If yes, what is your primary concern? _____

_____

Do you think that your child has a hearing problem? ☐ Yes ☐ No

If yes, what is your primary concern? _____

_____

Has your child ever had a speech language evaluation or screening? ☐ Yes ☐ No

If yes, when and where? _____
What were you told? _____

Has your child ever had a speech language therapy? ☐ Yes ☐ No

If yes, when and where? _____
What were you told? _____
Why are you switching therapists? _____

Is your child aware or frustrated by any speech/ language difficulties? ☐ Yes ☐ No

Please explain _____

_____

What do you see as your child's most difficult problem at home?

Please explain _____

_____

What do you see as your child's most difficult problem at school or daycare?

Please explain _____

_____

Does your child do any of the following: (Check all that apply) ☐ Not relevant for current situation

☐ Repeat sounds, words and phrases over and over
☐ Understand what you are saying
☐ Retrieve or point to common objects upon request
☐ Respond correctly to yes or no questions
☐ Respond correctly to who, what, when, where and how questions
☐ Follow simple instructions

Patient Information

Please read the following information carefully before signing.

1. Policies on fees & disclosed information

1.1 I understand that appointments not attended or cancelled with less than 24 hours' notice may incur a charge and that **payment is required at the time of consultation.**

1.2 I have disclosed any past or current illness, surgery, previous trauma, medications, drug use and any known health risks in the forms provided and agree to provide any related new information during the period of care at this clinic or by practitioners who have assessed or treated me at this clinic.

2. Missed Appointment Policy

2.1 Whilst we understand that there may be times when extenuating circumstances prevent you from attending your appointment or rescheduling your appointment at late notice, we must be strict, fair and consistent with all patients. By adhering to our Missed Appointment Policy, we aim not only to create a culture of mutual respect between patients, practitioners and staff, but to also improve health outcomes by ensuring a continuity of care.

2.2 Futures Wellness Clinic has a '3 strike' policy for accumulated missed appointments:

- Notification of missed appointment with opportunity to re-book at the next available time. You will be asked to refamiliarise yourself with Futures Wellness' Missed Appointment Policy.
- The full consultation fee will be charged for your missed appointment. Please be aware that you will not be able to book in any further appointments at Futures Wellness until this fee has been paid.

3. Privacy Collection Statement

3.1 We collect patient information so we can provide the best possible patient care. At times we may need to liaise with our patients' other treating health practitioners and specialists where appropriate, and with our patients' guardians or other responsible persons.

3.2 At times we may also be required to liaise with Medicare and our patients' private health insurance funds, and may need to deal with lawyers engaged by our patients, or by their private health insurance fund.

3.3 As such, we may need to disclose or allow access to patient information to others for the purposes listed above. We will never disclose patient information to overseas recipients.

3.4 If a patient does not provide us with the information we request, we may not be able to provide the patient care or products required or otherwise assist the patient.

3.5 Our Privacy Policy contains information about how individuals may access or correct personal information we hold about them, how they can complain about a breach of privacy and how we will deal with such complaints. You can find our Privacy Policy on our website at www.futureswellness.com.au or you can ask our reception staff for a copy.

4. Please Tick some or all of the following boxes as appropriate:

☐ I consent to Futures Wellness Clinic contacting me to promote their services and products

☐ I consent to Futures Wellness Clinic using and disclosing my personal information for the purposes described above.

Patient Name: _____ Date: _____

Signed: _____