Thank you for taking the time to complete the following questions. If you would prefer not to answer any of these questions, please indicate this by putting a line in the box (e.g. —).

Name of client:_____ **Date of Birth:**_____

Background Information

	Name	Date of Birth	Title (Mr/Mrs/Miss/ Ms/Dr/Mx etc)	Details of any developmental difficulties (e.g. Autism, ADHD, speech delay, dyslexia) or mental health problems)
Biological Mother	*Name*	*Date of Birth*		
Biological Father	*Name*	*Date of Birth*		
Name(s) of caregiving parents (if different from above):				
Details of developmental or mental health problems within the extended family:				

	Name of Sibling	Date of Birth	Age	Sex	Relationship (e.g. full sibling, adoptive sibling, half sibling)	Details of any developmental difficulties (e.g. Autism, ADHD, speech delay, dyslexia, mental health problems
1.						
2.						
3.						

4.						
5.						

Education and Schooling

Please provide as much information as possible about toddler groups, nurseries, schools and further education:

	Name of nursery/ school/ college/ university	Type of school (e.g. mainstream, independent, special school)	Age when attended		Additional support? If yes, please provide details	Grades Achieved (e.g. GCSE's)
			From (_Years_Months)	To (_Years_Months)		
1.						
2.						
3.						
4.						
5.						
6.						
7.						

8.						
9.						

Has the person ever received an Individual Education Plan (IEP), Statement of Special Educational Needs (SEN), or Education Health Care Plan (EHCP)?	Select *(please select from dropdown menu)*
Age when statemented (__Years__Months)	Details of statement (e.g. hours per week, focus of support):

Existing Diagnoses			
Diagnosis	Age when diagnosed (__Years__Months)	Type of professional who made diagnosis (e.g. psychologist, psychiatrist, pediatrician)	Any additional information e.g. medication

Pregnancy and birth

Were there any complications during pregnancy (e.g. any infections/viral illnesses/hospital admissions/other)? If yes, please provide details	Select *(please select from dropdown menu)*

Were any medications taken during pregnancy? If yes, please provide details on the medication, dose, frequency, and during which trimester

Name of medication	Dose	Which trimester(s)? Trimester 1 (1-12 weeks) Trimester 2 (13-26 weeks) Trimester 3 (27 - end of pregnancy)	Any other details

Did the mother of the person do any of the following activities during pregnancy?

	Trimester 1 (1 – 12 weeks)	Trimester 2 (13 – 26 weeks)	Trimester 3 (27 weeks – end of pregnancy)
Alcohol	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Please provide details (e.g. frequency & amount):			
Tobacco Products	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Please provide details (e.g. frequency & amount):			
Recreational Drugs	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Please provide details (e.g. frequency & amount):			

Maternal Age	Paternal Age
Age of mother at time of birth: ____years	Age of father at time of birth: ____years

Gestation	
When did the mother of the person go into labour? ____weeks	

How was the baby delivered? (Please provide details in box)	
VAGINAL	C-SECTIONAL
Forceps - Select *(please select from dropdown menu)*	Emergency Select *(please select from dropdown menu)*
Vacuum - Select *(please select from dropdown menu)*	Planned - Select *(please select from dropdown menu)*

Birth Weight

What was the person's weight at birth?

What were the baby's APGAR scores?

First APGAR (at 1 minute) score: _____ /10 or tick if not known ☐

Second APGAR (at 5 minutes) score: _____/10 or tick if not known ☐

Third APGAR (at 10 minutes) score: _____/10 or tick if not known ☐

Any complications during or immediately following birth? If yes, please provide details

Discharge from hospital following birth?

How long did the baby stay in hospital following birth?

Newborn period

Did the baby have any major problems in the newborn period (0-30 days of life)?

Select *(please select from dropdown menu)*

If yes, please provide details:

Daily Living, Sensory and Motor Functioning

Does the person have difficulties managing basic activities of daily living? Such as dressing, feeding and self-care?
Has the person ever had difficulties with fine motors skills (e.g. doing up buttons, writing or playing video games) or gross motor skills (e.g. walking, running, kicking or throwing a ball)?
Does the person have any sensory processing difficulties? (e.g., touch, hearing, taste, smell, sight, internal sense of body awareness, touch and/or movement).

Speech and Language

Has the person ever received Speech and Language Therapy?	Select *(please delete as appropriate)*					
Who suggested referral? (e.g. parent, health visitor, GP)	Age when referred (__Years__Months)	Age when started sessions (__Years__Months)	Frequency of sessions (e.g. weekly, monthly)	Age when finished sessions (__Years __ Months)	One-to-one or group sessions?	Focus of sessions (e.g. delayed speech, pronunciation)

Milestones			
Age when first used single words (other than 'mama'/ 'dada') (__Years__Months)		Age when first used simple phrases including a verb (e.g. "go park see ducks") (__Years __Months)	
Examples:		*Examples:*	

Walking
When did the person first walk unaided? _____ Months
Bladder Control - Day
At what age did the person gain full control of their bladder during the day (i.e. when did they completely stop having accidents)? _____ Years _____ Months
Bladder Control – Night
At what age did the person gain full control of their bladder at night time (i.e. when did they completely stop having accidents)? _____Years _____ Months
Bowel Control
At what age did the person gain full control of their bowels (i.e. when did they completely stop having accidents)? _____Years _____Months
Current communication
How does the person communicate their needs now? What for? Please provide examples:
Are you having any difficulties with communicating with the person, either understanding them or them understanding you?

Can the person understand words across different contexts and show their understanding by getting/showing?
Are you able to play with the person? How long does this last? Please provide examples.
Has there ever been a time that the person lost any skills (e.g. language, motor, hand movements, self-help, imaginative play, social engagement or responsiveness).

Signed: _____ Date: _____

Title: (Mr/Mrs/Miss/Ms/Dr/Mx etc)_____

Print Name:

_____

Thank you for your time completing this form.