

**PLEASE COMPLETE QUESTIONNAIRE AND
BRING TO CHILD'S APPOINTMENT**



**Suite 1/ 601-603 Anzac Highway, Glenelg North p 8376 0999
51 Angas Street , Adelaide p 8410 2900**

Child Client Information Form

Child name: _____ Date of Birth: _____

Parent's Names: _____

Address: _____ P/Code: _____

Phone No: _____ Mobile: _____ Work No: _____

Email Address: _____

Is the child of Aboriginal or Torres Strait Islander origin? No Yes, Aboriginal Yes, Torres Strait Islander

Family Dr & Address: _____

How did you hear about us? _____

Do you have private health insurance with 'Extras' cover? NO YES – Which Fund? _____

Does your child have a history of:

Details

- speech or language problems? No Yes _____
- ear infections? No Yes _____
- hearing loss in family? No Yes _____
- recurrent colds / upper respiratory infection? No Yes _____
- reported pain or tenderness in the ear? No Yes _____
- major head trauma? No Yes _____
- developmental disorder or delay? No Yes _____

Has your child seen an Ear, Nose and Throat Specialist (ENT)? No Yes

If yes, who and when? _____

Has your child had any surgery or treatment for ear or hearing problems? No Yes

If yes, where and when? _____

Has your child had a hearing test before? No Yes

If yes, where and when? _____

Authority to release confidential audiological information:

I _____ *(print your name)* hereby authorise the release of information regarding my child's audiological assessment to other service providers. This information is to be used to manage my child's case and to assist in my child's rehabilitation/training program.

Signature _____ Date ____/____/____