States of Guernsey
Children and Family
Community Services

Children's Speech and Language
Therapy Service
Les Marais Centre
Le Grand Bouet
St Peter Port
Guernsey
GY1 2SB
+44 (0) 1481 227760
www.gov.gg/SLT

Parent Questionnaire

Child's Name:	Date of birth:	Male: ☐ Female: ☐
Address:		
		Post Code:
Telephone Nos: (Home):	(Work):	GP:
Your name:	Relationship to child:	
Who lives at home?		
Any siblings? (names/ages):		
Language/s spoken at home:		

Developmental Milestones

Did your child have difficulties in the following areas? If YES, please comment.			
Sitting up on his/her own	YES ☐	NO ☐	
Crawling	YES ☐	NO ☐	
Walking on his/her own	YES ☐	NO ☐	
Toilet Training	YES ☐	NO ☐	

Communication Milestones

Did your child have any difficulties/delays in the following? If YES, please comment.			
Using his/her first words	YES ☐	NO ☐	
Using sentences	YES ☐	NO ☐	
Understanding words	YES ☐	NO ☐	
Did you or anyone else have concerns about your child's communication before they went to school? YES ☐ NO ☐			
If YES, please give details…			

Do you have any concerns about your child's communication now?		
Understanding Instructions	YES ☐	NO ☐
Expressing themselves using words	YES ☐	NO ☐
Making their sounds clear	YES ☐	NO ☐
Voice quality e.g. hoarse voice	YES ☐	NO ☐
Stammering; being able to say words smoothly	YES ☐	NO ☐

Getting on with other children and/or adults	YES □	NO □
Being worried to talk in some situations e.g. at school	YES □	NO □
If you answered YES, to any of the above, please give more details		

Health

Does your child have a medical diagnosis? YES □ NO □			
If YES, please state.			
Is your child taking any medication? YES □ NO □			
If YES, please list.			
Has your child had a significant illness or injury that required a stay in hospital? YES □ NO □ If YES, please provide further information.			
Has your child ever had any difficulties with eating and/or drinking? YES □ NO □ If YES, please provide further information.			
Has/Does your child suffer from a high number of….			
Ear infections	YES □	NO □	
Colds	YES □	NO □	
Coughs	YES □	NO □	
Chest Infections	YES □	NO □	
Has your child had a recent hearing test? YES □ NO □			
Do you have any concerns about your child's hearing? YES □ NO □ If YES, please provide further information.			

Additional Comments

Consent

Please tick the boxes and sign below in order to give your consent. Your child will not be seen until this form is returned to the speech and language therapy department:

- ☐ I consent to the above details being stored securely within my child's medical records.
- ☐ I consent to the Speech and Language Therapy Department using the above details to form part of assessment towards my child's strengths and needs.
- ☐ I consent to my child taking part in assessment of their speech, language and/or communication within school (this may be formal/informal assessment in a 1:1 session or observation within the school day).
- ☐ I consent to my child receiving therapy (if required) within school (led by the speech and language therapist, supported by school staff).

Signed:……(parent/guardian) **Date:**……

Thank you for taking the time to complete this questionnaire.

Please return the questionnaire to school or to the following address: **Children's Speech and Language Therapy Service, Les Marais Centre, Le Grand Bouet, St Peter Port, GY1 2SB**