**PRIVATE AND CONFIDENTIAL**

**CHILDREN’S THERAPIES SERVICE**

**PARENTAL INFORMATION FOR REFERRALS**

**It would help the therapist to have the following information:**

* **What are your concerns?**

Does your child seem to have any difficulties with any of the following at home? (*Please tick Yes / No*)

* Speech and language (talking, understanding etc.) Yes No

If yes, please give examples of your concerns:

* Physical difficulties (movement, coordination etc.) Yes No

If yes, please give examples of your concerns:

* Please give examples of how these concerns impact on your child’s everyday life:

**Developmental Details**

* Were there any pregnancy or birth complications, including postnatal depression? Yes No

(*If yes, please give details*)

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* At what age did your child:
	+ Roll over \_\_\_\_\_\_\_\_
	+ Sit \_\_\_\_\_\_\_\_
	+ Walk \_\_\_\_\_\_\_\_
	+ Say their first words \_\_\_\_\_\_\_\_
* Is your child toilet trained? Yes No
* What does your child like to play with:

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**Personality**

* Please describe your child’s personality:

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* Do you have any concerns about your child’s behaviour? Yes No

If yes, please give details:

**General Health**

* Does your child have any of the following health problems?(*Please tick*)

Ear infections / colds / asthma 🞏

Allergies 🞏

Medications 🞏

Other (please specify) 🞏

* Please give details and approximate dates of any illnesses, hospitalisations or serious accidents:

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