Appendix H.1
Questionnaire 1: Developmental History

1. Child's name:
2. Child's date of birth:
3. Please list your other children (if any) by age and date of birth:

Children	Age	Date of birth

4. Was your child born prematurely? YES/NO
5. Were there any complications associated with the birth? YES/NO
6. Did your child have any feeding difficulties? YES/NO
7. Does your child suffer from any of the following:

Allergies	YES/NO
Fits	YES/NO
Asthma	YES/NO
Frequent coughs and colds	YES/NO
Ear infections	YES/NO
Catarrh	YES/NO

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II. DEVELOPMENT SINCE BIRTH

Physical development

8. Approximately how old was your child when s/he began to walk?
9. Have you ever been worried about your child's physical development? YES/NO

If Yes: 9a. What caused this concern?

9b. Was any help/treatment sought for this? YES/NO
If Yes: 9c. Was help/treatment given? YES/NO
9d. Are there still problems? YES/NO

Hearing

10. Have you ever been worried about your child's hearing?YES/NO

If Yes: 10a. What caused this concern?

10b. Was any help/treatment sought for this? YES/NO
If Yes: 10c. Was help/treatment given? YES/NO
10d. Are there still problems? YES/NO

Speech and Language

11. Approximately how old was your child when s/he began to talk?
12. Have you ever been worried about your child's speech or language development? YES/NO

If Yes: 12a. What caused this concern?

12b. Was any help/treatment sought for this? YES/NO
If Yes: 12c. Was help/treatment given? YES/NO
12d. Are there still problems? YES/NO

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Vision

13. Have you ever been worried about your child's vision? YES/NO

If Yes: 13a. What caused this concern?

13b. Was any help sought for this? YES/NO

If Yes: 13c. Was help/treatment given? YES/NO

13d. Are there still problems? YES/NO

Reading and Spelling

14. Have you been worried about your child's reading? YES/NO

If Yes: 14a. What caused this concern?

14b. Was any help sought for this? YES/NO

If Yes: 14c. Was help given? YES/NO

14d. Are there still problems? YES/NO

15. Have you been worried about your child's spelling? YES/NO

If Yes: 15a. What caused this concern?

15b. Was any help sought for this? YES/NO

If Yes: 15c. Was help/treatment given? YES/NO

15d. Are there still problems? YES/NO

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III. FINAL SECTION

Please use this space if there is any more information you would like us to have.

Name:____________________________

Signed:___________________________

Date:_____________________________

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Appendix H.2
Questionnaire 2: Family Information

PARENTAL QUESTIONNAIRE: A SEPARATE QUESTIONNAIRE SHOULD BE COMPLETED BY EACH PARENT

I. GENERAL DETAILS

1. Name:
2. Child's name:

II. EDUCATIONAL DETAILS

3. Number of CSE, GCSE or GCE 'O' level passes:
4. Number of GCE 'A' level passes:
5. Qualifications gained in further or higher education:
6. Any other qualifications:

III. OCCUPATIONAL DETAILS

Please give your present occupation. (If you are unemployed or are engaged in full-time child care, please give your previous occupation.)

7. Post/Title:

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IV. SELF AND FAMILY

8. Do you or any of the following members of your family have a history of reading/spelling difficulties?

You	YES/NO
Your parents	YES/NO
Your grandparents	YES/NO
Your brothers/sisters	YES/NO

9. Do you or any of the following members of your family have a history of speech difficulties?

You	YES/NO
Your parents	YES/NO
Your grandparents	YES/NO
Your brothers/sisters	YES/NO

10. Have you ever attended a speech therapy clinic? YES/NO
11. Have you ever had a hearing loss? YES/NO

V. FINAL SECTION

Please use this space if there is any more information you would like us to have.

Name:__________________________
Signed:_________________________
Date:___________________________

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Appendix H.3
Questionnaire 3: Educational History

Child's name: Year Group:

1. Name and level of reading scheme:

2. Does the child have any difficulties with reading or spelling? YES/NO

3. Does the child have any difficulties with any other subjects? YES/NO

4. Is the child receiving any extra help? YES/NO

If Yes:

4a. How much extra help a week?
4b. In what format (group, individual)?
4c. Who gives the extra help?
4d. Where does the help take place (class, out of class, home)?

5. How much phonics work does the child receive each week?
6. Is the child statemented? YES/NO
7. Is the child in School Action? YES/NO
8. Does the child have an IEP? YES/NO
9. Is the child in School Action Plus YES/NO
10. Has the school requested Statutory Assessment? YES/NO

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11. SATS results (if appropriate) or other

Reading	Comprehension	Writing
Spelling	Maths	

Please use this space for any comments you would like to make:

Signed:__________________________
Name:___________________________
Date:____________________________

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Appendix H.4
Questionnaire 4: Speech and Language Therapy

Child's name:
Child's date of birth:

* Please report on the time period from 1st referral to Speech and Language Therapy (SLT) up until present time or provide an alternative starting date for the time period from which information is provided, e.g. when this child came onto your case load.

Alternative starting date for period reported:

1. Date of referral to SLT service*:
2. Date of initial appointment:
3. Number of sessions offered during the above period*:
4. Number of sessions attended during the above period*:
5. Number of individual sessions*:
6. Number of group sessions*:
7. Approximate length of session:
8. Type of therapy (tick as appropriate), and give % estimate of time employed on each type:

    - ❑ phonological (e.g. minimal pairs, metaphon) ___ %
    - ❑ oral motor skills ___ %
    - ❑ articulatory therapy ___ %

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- ❑ phonological awareness ___ %
- ❑ expressive language ___ %
- ❑ receptive language ___ %
- ❑ play skills ___ %
- ❑ listening skills ___ %
- ❑ social skills ___ %
- ❑ parent workshop ___ %
- ❑ parent-child interaction ___ %
- ❑ other (please specify)________________________________ %

9. Therapy setting (tick as appropriate):

- ❑ clinic
- ❑ school
- ❑ language unit
- ❑ other (please specify)_______________________

10. How often did liaison take place between SLT and nursery/school? (tick as appropriate):

- ❑ Once a year
- ❑ Once a term
- ❑ Occasional
- ❑ None to date
- ❑ Other (please specify)_______________________

11. What was the management of the child during the above period*? (tick as appropriate):

- ❑ regular for therapy
- ❑ on review
- ❑ on waiting list
- ❑ planned discharge
- ❑ discharged
- ❑ other (please specify)_______________________

12. Is the child (tick as appropriate):

- ❑ not statemented (i.e. no plans to begin process)
- ❑ statemented or in receipt of School Action or other intervention

13. Any other changes/observations of note (e.g. failed hearing test, change of school, hospitalisation):

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14. Please specify other agencies involved (tick as appropriate):

- ❑ ENT
- ❑ OT
- ❑ Physio
- ❑ Ed. Psychologist
- ❑ Social Worker
- ❑ Child Guidance
- ❑ Other (please specify)______________________

15. Other comments:

Signed:_________________________
Name of therapist:______________
Base:___________________________
Date:___________________________

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