PERSONAL HISTORY *(Please circle when necessary)*

Is the child living with (*Please circle*)

Both parents Mother Father Other

If other please specify

_____

Are there any other relatives living with the family?

_____

_____

MOTHER Primary Caregiver

First name_____ Last name_____ Profession_____

Address_____ City_____ State_____ Postcode _____

Country_____ Home Phone_____ Mobile Phone_____

Work Phone_____ E-mail_____

FATHER Primary Caregiver

First name_____ Last name_____ Profession_____

Address_____ City_____ State_____ Postcode _____

Country_____ Home Phone_____ Mobile Phone_____

Work Phone_____ E-mail_____

REASON FOR CONSULTATION

Please describe as precisely as possible the reasons why you want your child to be assessed:

_____

_____

_____

_____

_____

Please describe the issue(s) background (When, how, why did it start):

_____

_____

_____

_____

_____

_____

When did you notice the issue(s)?

Please describe in which situations these above difficulties occur?

BIRTH HISTORY *(Please circle when necessary)*

If your child was adopted, please answer the following questions.

Which country was he/she adopted in? _____

At what age was he/she adopted? _____

Do you have any information concerning the history of your child before adoption?

Language(s) other than English spoken during the pregnancy?

By the father _____

By the mother _____

Other carer _____

Please specify name(s) and age(s) of other siblings

Were there any complications, illnesses, or stresses during the pregnancy?
Yes/No

If yes, please specify

_____
_____
_____
_____
_____

Where there any miscarriages before this pregnancy? Yes/No

Was your child born full term? Yes/No

Premature, how many weeks gestation? _____

Postmature, how many weeks of gestation? _____

How long was the labour? (*In hours, if possible*) _____

Birth type Vaginal birth Forceps Suction/Vacuum

Caesarean Planned Emergency

Was labour/ delivery difficult? Yes/No

Did your child receive antibiotics at birth? Yes/No

Was your child in the NICU (Neonatal Intensive Care Unit)? Yes/No

If yes, why and for how long? _____

Circle all that apply to your child before discharge.

Intubation Oxygen Orogastric tube feeding Nasogastric feeding tube Surgery

Please describe

_____
_____
_____
_____
_____

Has your child ever been diagnosed with gastro oesophageal reflux? Yes/No

Did your child spit up/ vomit? Yes/No

If yes, how often? _____

Newborn hearing screening? Yes/No

DEVELOPMENT HISTORY *(Please circle when necessary)*

Has your child been diagnosed with any medical conditions? Please specify?

_____
_____
_____
_____
_____

Has your child received any other interventions or therapies? Yes /No

If so, please specify which ones and when

_____
_____
_____

Has your child been diagnosed with a visual impairment? Yes/No

Does your child wear glasses? Yes/No

Has your child been diagnosed with an auditory impairment? Yes/No

Did your child crawl? Yes/No

When did your child sleep through the night?

_____
_____
_____
_____

At what age did your child sit? _____

At what age did your chid walk? _____

At what age was your child toilet trained?

Day time _____

Night time _____

Which hand does your child favour? Right Left Both

Which leg/ foot does your child favour? Right Left Both

Does your child like to swing? Yes/No

Is your child sensitive to fabrics/ textures? Yes/No

Tags in clothing? Yes/No

Is your child overly sensitive in general? Yes/No

Is your child irritable? Yes/No

Does your child have good eye contact? Yes/No

Does your child follow faces or objects?
Yes/No

Does your child like to play with? Sand Grass Playdough
Water

Does your child exhibit the following behaviours?

Self-stimming Rocking Head banging Flicking

MEDICAL HISTORY *(Please circle when necessary)*

Medication *(please include over the counter medications, herbal products, supplements and vitamins)*

_____
_____
_____
_____

Has you child been in any accidents? Yes/No

If yes please specify

_____
_____
_____

Has your child ever been hospitalized? Yes/No

If yes, please explain

_____
_____
_____

Please list all the specialists your child has visited;

_____
_____
_____
_____
_____

Has your child had any of the following procedures?

ECG (electrocardiogram) EEG (electroencephalogram) MRI (magnetic resonance imaging)

Other:

_____
_____
_____

Does your child have a diagnosed seizure disorder? Yes/No

When was it diagnosed?

At what age did the first seizure start? _____

How often does your child have seizures? _____

Is your child monitored by a doctor? _____

If yes please specify the medication.

ENT HISTORY *(Please circle when necessary)*

Does your child do any of the following;

Snore	Breath loudly while asleep
Breathe loudly at rest	Keep mouth open often
Breathe loudly during activity	Tend to stick out tongue

Does your child have any of the following;

Colds	Pneumonia
Bronchitis	Thrush
Upper respiratory infections	Bad diaper rash
Ear infections	

If so, how often?

Has your child had any problems with their tonsils or adenoids? Yes/No

If yes, please explain

Does your child present with any of the following conditions (check all that apply)?

Earaches	Nose bleeds
Ear discharge	Sleep apnoea
Tinnitus (ringing in ears)	Facial pain/ Pressure
Hearing loss	Sore throat
Sinus trouble	Voice hoarseness/croakiness
Nasal congestion/runny nose	Dysphagia (trouble swallowing)

Is your child overly sensitive to loud sounds or noises?			Yes/No
Does your child hear sounds others don't, or before others notice?			Yes/No
Is your child able to pay attention in a noisy environment?			Yes/No
Is your child's language hard to understand?			Yes/No
Does your child mispronounce words?			Yes/No
Does your child frequently ask you to repeat what you said?			Yes/No
Does your child rarely participate in conversations?			Yes/No
Does your child need visual cues to respond to verbal instructions?			Yes/No
Does your child seem to not hear the beginning or middle of statements?			Yes/No
Does your child cover his/her ears to avoid auditory input?			Yes/No
Does your child "tune out" or ignore sounds from the environment?			Yes/No
Does your child hum, sing softly, or self-talk through these tasks?			Yes/No
Is your child's voice volume too loud?	Loud	Quiet	N/A
Does your child respond when his/her name is called?			Yes/No
Is your child slow or delayed in responding?			Yes/No
Does your child enjoy making strange noises or repetitive sounds?			Yes/No
Does your child have difficulty in using proper words?			Yes/No
Does your child have a limited use of descriptive vocabulary?			Yes/No

ALLERGIES/SENSITIVITES *(Please circle when necessary)*

Does your child suffering from food or environmental allergies or sensitivities? Yes/No

Has your child ever been tested for allergies? Yes/No

If yes, please specify the types of test and results

_____
_____
_____
_____

Has your child ever suffered from eczema? Yes/No

Asthma Yes/No

If yes, please specify since when?

_____
_____
_____

Other rashes? Yes/No

Yeast infections? Yes/No

Does your child suffer from gut issues? Yes/No

If yes, please specify

_____
_____
_____

Does anyone in your family suffer from any allergies or food intolerances? Yes/No

If yes, please specify the relationship to the child and what are they allergic or sensitive to:

_____
_____
_____

ORAL MOTOR HISTORY *(Please circle when necessary)*

Does your child drool? Yes/No

Is brushing teeth difficult? Yes/No

When did your child get his/her first tooth? _____

Does your child currently mouth objects? Yes/No

Did he/she do it in the past beyond what is age appropriate?
Yes/No

Does your child currently use a pacifier or suck his/her thumb?
Yes/No

Did he/she in the past, beyond what is age appropriate? Yes/No

SLEEPING HISTORY *(Please circle when necessary)*

What time does your child wake up? _____

What kind of mood is your child in when waking? _____

What time does your child go to bed at night? _____

Where does your child sleep?

In his/her room In his/her room with sibling

With parents With relative

Describe bedtime routine, how long does it take?

_____

_____

_____

Does your child have difficulties with falling asleep? Yes/No

Does your child sleep through the night? Yes/No

Does your child wake at night? Yes/No

If yes, what time? _____

Does he/she need a light to fall asleep with? Yes/No

What activities do you use to get your child back to sleep?

Rocking Massage

Singing Holding

Bouncing None

Humming

Other:

_____

_____

_____

How old was your child when he/she started to sleep through the night?

_____

_____

Does your child sleep during the day? Yes/No

Which activities do you use as a part of your child's bedtime routine?

Bath time Reading

Singing Rocking

Bouncing Holding

Massage None

What happens if this routine is disrupted?

_____

_____

_____

What does your child do when he/she awakens?

Whimper Go back to sleep on their own

Scream Go to parents

Plays with toys

Other:

_____

_____

_____

FEEDING

Was your child breastfed? Yes/No

Up to what age? _____

Did your child attach well to the breast? Yes/No

When did you stop breastfeeding? _____

Did he/she wean him/herself? Yes/No

If yes, please explain

_____

_____

_____

Have you ever forced your child to eat? Yes/No

Is your child a pick/fussy eater? Yes/No

Does your child have a reduced appetite/limited intake? Yes/No

Is your child not progressing to age appropriate foods? Yes/No

Is your child showing an appetite and then refusing to eat? Yes/No

Does your child suffer with; Constipation Diarrhea Tummy ache

GOALS

What results would you like your child to achieve with the Tomatis® listening program?

Eg: better auditory processing.

Dr Donna Palmer Level 4 Tomatis Consultant and Practicing MSL Educational Specialist (IMSLE, Aus). AMADA Registration: 420070
How to get in contact:
Website - www.tomatisinstitutesa.com.au
Email - info@tomatisinstitutesa.com.au
Phone - 08 8569 1777

Australian Dyslexia Association
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Institute for **Multisensory Structured Language** Education