

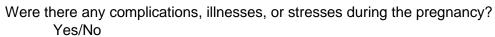


Is the child living with (Please circle)

Both parents	Mother	Father	Other	
If other please	e specify			
	other relatives living			
MOTHER	Primary Caregiver			
				ssion
				Postcode
Country	Ho	me Phone_	Mobi	le Phone
Work Phone_	E-ma	il		
FATHER	Primary Care	egiver		
First name	Last	name	Profes	ssion
Address	Ci	ty	State	Postcode
Country	Ho	me Phone_	Mobi	le Phone
Work Phone_	E-ma	il		
	R CONSULTATION be as precisely as po	ssible the rea	asons why you want	your child to be
Please descri	be the issue(s) backg	round (Wher	n, how, why did it sta	art):



When did you notice the	issue(s)?			
Please describe in which	n situations these a	bove difficulties	s occur?	
BIRTH HISTORY (Pleas	e circle when necess	sary)		
If your child was adopted	d, please answer tl	ne following que	estions.	
Which country was he/sl	ne adopted in?			
At what age was he/she	adopted?			
Do you have any informa	ation concerning th	e history of you	ır child before adoptio	on?
Language(s) other than	English spoken du	ring the pregna	ncy?	
By the father				
By the mother				
Other carer				
Please specify name(s)	and age(s) of othe	r siblings		



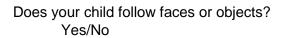


If yes, pleas	se specify			
Where there	e any miscar	iages before this pregn	nancy?	Yes/No
Was your ch	nild born full	term?		Yes/No
Premature,	how many w	eeks gestation?		
Postmature,	, how many v	veeks of gestation?		
How long wa	as the labou	? (In hours, if possible)		
Birth type		Vaginal bir	rth Forceps	Suction/Vacuum
Caesarean			Planned	Emergency
Was labour/	delivery diff	cult?		Yes/No
Did your chi	ld receive ar	tibiotics at birth?		Yes/No
Was your ch	nild in the NI	CU (Neonatal Intensive	Care Unit)?	Yes/No
If yes, why a	and for how I	ong?		
Circle all tha	at apply to yo	ur child before discharg	ge.	
Intubation	Oxygen	Orogastric tube feedi	ing Nasogastric fee	eding tube Surgery
Please desc	cribe			
Has your ch	ild ever beer	n diagnosed with gastro	oesophageal reflux?	Yes/No
Did your chi	ld spit up/ vo	mit?		Yes/No
If yes, how o	often?			
Newborn he	aring screer	ing?		Yes/No



DEVELOPMENT HISTORY (Please circle when necessary)

Has your child been diagnosed with any medical conditions?	Please spec	city? 	
Has your child received any other interventions or therapies?)		Yes /No
If so, please specify which ones and when			
Lac your shild been diagnosed with a viewal impairment?			Vaa/Na
Has your child been diagnosed with a visual impairment?			Yes/No Yes/No
Does your child wear glasses? 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?			103/110
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 like to play with?
Water

When was it diagnosed?

Sand Grass Playdough

Does your child exhibit the following behaviours?

Self-stimming	Rocking	Head banging	Flicking
Con curring	1 100111119	i ioaa banging	1 110111119

MEDICAL HISTORY (Please circle when necessary)	
Medication (please include over the counter medications, herbal products, supports vitamins)	olements and
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 resona	ince imaging)
Other:	
Does your child have a diagnosed seizure disorder?	Yes/No



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 tor	nsils 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

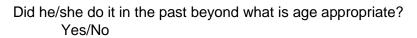
Nasal congestion/runny nose Dysphagia (trouble swallowing)

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 Loud Quiet N/A Is your child's voice volume too loud? 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 Yes/No Does your child have a limited use of descriptive vocabulary?



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 s	ensitive 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





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 aslee	ep?	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 s	leep 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	TOM
Bouncing	Holding	
Massage	None	
What happens if this routine is disrupted?	146116	
What does your child do when he/she awaken	s?	
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/limite	d intake?	Yes/No
Is your child not progressing to age appropriate	e foods?	Yes/No
Is your child showing an appetite and then refu	using to eat?	Yes/No

Constipation

Diarrhea

Tummy ache

Does your child suffer with;



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:

 $Website - \underline{www.tomatisinstitutesa.com.au} \\ Email - \underline{info@tomatisinstitutesa.com.au}$

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