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 707760
www.gov.gg/SLT

Parent Questionnaire

This questionnaire is designed to help us to gain an insight into your child's development and communication history and what the main concerns/difficulties are.
Please fill in as much as you can.
Feel free to contact us if you have any questions about the referral and/or 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:		

Does your child currently have difficulties with:			
Writing?	YES ☐	NO ☐	
Reading?	YES ☐	NO ☐	
Playing sport?	YES ☐	NO ☐	
Being sociable with others?	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 □	
Being understood by others	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 □
Being able to express themselves clearly in all situations. This includes with familiar and unfamiliar people.	YES □	NO □
Understanding stories.		
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 □

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/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 ☐			

Have you discussed the referral to our service with school?	YES ☐	NO ☐
What outcome would you like to see from our involvement?		
Does your child know about the referral to the service?	YES ☐	NO ☐
What outcome would your child like to see from our service?		

Additional Comments

Signed…… 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**