Speech and Language Therapy Experience Questionnaire

This questionnaire will be used to assist you and your potential employer to determine which Speech and Language Therapy settings would be best suited to your skills and experience. It will also help us identify areas for future training and development.

Contact Details

Name:

Country:

Email Address:

Number of years' experience of working with people with PH/MH problems:

Q1

TREATMENT SETTINGS EXPERIENCE IN SPEECH AND LANGUAGE THERAPY

Please indicate whether you have ever worked in the Occupational Therapy settings below by inserting **Y** or **N** in the appropriate column. If yes, please state approximately how many years' experience you have had. Please use the comments column to tell us any additional information

Treatment Setting	Yes / No	If Yes, Approximate Numbers of Years	Comments
Inpatient rehabilitation ward			
Community SLT for adults in their own homes			
Community neurological rehabilitation			
Older people's mental health wards			
Older People Mental health SLT in community			
Nursing / Residential Homes			

Q2

PHYSICAL AND MENTAL HEALTH ILLNESS EXPERIENCE

Please indicate whether you have experience in caring for people with the physical and mental health problems below by replying **Y** or **N** in the appropriate column. If yes, please state approximately how many years' experience you have had. Please use the comments column to tell us any additional information

Physical and Mental Health Illness	Yes/ No	If yes, approximate numbers of years	Comments
Complex elderly patients with Long term conditions			
Neurological conditions (MS, MND, PD, Brain injury and stroke etc)			
Dementia/Alzheimer			
ENT/voice disorders			
Respiratory Disorders			
Tracheostomy			
Mental Health Conditions			
Reflux			
Voice/swallowing disorders related to Long Covid			

Q3

ASSESSMENT EXPERIENCE

Please tell us about the tools used in your SLT practice to assess the following by replying **Y** or **N** in the appropriate column. If yes, please state which tools/questionnaires you have used. Please use the comments column to tell us any additional information

Assessment tools	Yes / No	If yes, please insert which tools you have used	Comments
Dysphagia - Please describe level of dysphagia experience / competency			
Videofluoroscoopy/Fees			
Receptive aphasia			
Expressive aphasia			
Functional Language			
Dysarthria			
Apraxia			
AAC-Low tech/High Tech			
Cognitive impairment			
Voice impairment			
Other			

Q4

PHYSICAL AND MENTAL HEALTH INTERVENTIONS EXPPERIENCE

Please indicate your experience in delivering interventions by replying **Y** or **N** in the appropriate column. If yes, please state approximately how many years' experience you have had. Please use the comments column to tell us any additional information.

Interventions	If yes, approximate numbers of years	Comments
Functional assessment of patient presentation		
Rehabilitation needs assessment and intervention planning (Please describe in relation to condition related areas listed above)		
Group Therapy		
Assessment and provision of AAC equipment		
Cognitive Behavioural Therapy		
Family therapy or family-based interventions		
Mindfulness		
Counselling		

Q5

AGE-SPECIFIC EXPERIENCE

Please indicate your experience with working in the following age ranges by replying **Y** or **N** in the appropriate column. If yes, please state approximately how many years' experience you have had. Please use the comments column to tell us any additional information

Age Experience	Yes / No	If yes, approximate numbers of years	Comments
School age (ages 6-12 years)			
Adolescents (ages 12-18 years)			
Adults (ages 18-65 years)			
Older adult (ages 65 +)			

Q6

ANY OTHER INFORMATION

Please share any other information which may be relevant to working with people with physical and mental health problems
