



CONFIDENTIAL PAEDIATRIC – CASE HISTORY FORM

The information you provide on this form will give us a better understanding of your child and assist us in the assessment process. *All material and information is strictly confidential.*

Please bring the completed form to your initial appointment.

Date: _____ Person completing this form _____

Relationship to child (parent, teacher, etc): _____

Description of the problem _____

What do you hope to obtain from this assessment?

General Information

CHILD'S NAME: _____

Date of Birth: _____ Age: _____

MOTHER'S NAME: _____ **Mob phone:** _____

Mother's occupation: _____ **Home phone:** _____

E mail address: _____ **Bus. Phone:** _____

FATHER'S NAME: _____ **Mob phone:** _____

Father's occupation: _____ **Home phone:** _____

E mail address: _____ **Bus. Phone:** _____

Names of Siblings and ages: _____

Does your child live with both parents? _____

With whom does your child spend most of his/her time during the week?

Who is your child's GP? _____

Address of GP: _____ Phone Number: _____

Has the GP created a care plan for your child? Yes/No

Please list other professionals involved with your child's care now or in the past
(Psychologist, Speech Pathologist, Occupational Therapist, Ear Nose Throat, Audiologist, tutors etc.)

It is appreciated if you would provide copies of reports collected from other specialists.

Any known medical conditions/diagnoses? Yes/No

If Yes please detail: _____

Is English your child's primary language? Yes / No

If no, what other languages does the child speak? _____

Is your child aware of any difficulties they may be having? Yes/No

If yes, how does he/she feel about it? _____

Have any other speech pathologists or occupational therapists seen your child?

If yes, please note who and when? _____

Please indicate date administered and results of the following (if applicable):

Vision Testing: _____

Does your child wear glasses for reading/close work Yes/No

Hearing Test: _____

Are there any other speech, language, learning, reading, attention or hearing problems in your family? If yes, please describe. _____

Prenatal and Birth History

Mother's general health during pregnancy (illnesses, accidents, medications, etc.):

Please describe any complications during pregnancy/delivery: _____

Number of weeks gestation? (i.e. of pregnancy at birth) _____

Medical History

Please list at what age your child had any of the following conditions (if applicable):

Allergies (type):	Asthma:	Dizziness:
Ear infections:	Frequent Colds:(More than 6 per year)	
Headaches:	High fever:	Influenza:
Seizures:	Sinusitis:	Tonsillitis:
ADD/ADHD:	Other:	

Has your child had any surgeries? If yes, what type and when (e.g., tonsillectomy, adenoidectomy, etc.)? _____

Is your child up to date on their vaccines? Yes/No

Describe any major accidents or hospitalizations: _____

Is your child taking any medications? If yes, please list. _____

Developmental History

Provide the approximate age at which your child began to do the following activities:

Roll Over: _____ Sit: _____ Crawl: _____

Walk: _____ Feed self: _____ Toilet Trained: _____

Use single words (e.g., no, mum, doggie, etc.): _____

Name simple objects (e.g., dog, car, tree, etc.): _____

Combine words (e.g., me, go, daddy shoe, etc.) _____

Engage in conversation: _____

- How does your child primarily communicate (Please circle: gestures, single words, short phrases, sentences, conversation, other _____)
- Is their speech clear (compared to other children of the same age)? Yes/No
- Describe your child's response to sound (Please circle: responds to all sounds, tolerate loud noises, responds to loud sounds only, inconsistently responds to sounds, etc.) Yes/No

Educational History

School: _____ Year: ____ Teacher(s) _____

Day care attended : _____ Days _____ Carer: _____

If at kindergarten , how does your child sit through mat time? _____

Has his/her teacher reported any concerns to you? _____

Have you reported any concerns to the teacher? _____

How is your child doing academically (or pre-academically)? Please comment

Does your child enjoy school? _____

Does your child enjoy reading? _____

Does your child enjoy being read to? _____

If your child is of school age, how would you describe his/her handwriting/colouring (neat, sloppy, average)? _____

Social History

Tick the box that best describes your child:

- Aggressive relaxed
- Happy fearless/impulsive
- Curious easygoing
- Passive unhappy
- fearful/anxious friendly
- shy/withdrawn

• Does your child have difficulty separating from you? _____

• How does your child interact with others? (e.g., shy, aggressive, uncooperative, etc.) _____

• Does your child make friends easily? Yes/No

• Do you have any concerns about your child's social skills or ability to make/keep friends? Yes/No

• Does your child relate well with?

Adults? Yes/No/Sometimes

Parents? Yes/No/Sometimes

Grandparents? Yes/No/Sometimes

Siblings? Yes/No/Sometimes

Peers? Yes/No/Sometimes

Teachers? Yes/No/Sometimes

Please provide any additional information that might be helpful

Leisure/ Play

What types of activities does your child like to do

- Indoor _____
- Outdoor _____
- Organised Community/sports _____

Is your child able to: (please circle)

- play alone
- alongside others
- co-operatively
- play imaginative games
- play purposefully
- follow rules
- takes turns
- finish games they start
- lead the play
- follow the play
- take care of toys

What is your child's favourite toy/activity? _____

What activity/toy does your child least enjoy _____

How long does your child spend playing with their favourite toy/activity at a time?

Cognitive/Behavioural

Is your child?

- easily distracted
- very restless, difficulty keeping still
- excitable
- impulsive
- able to follow simple directions?
- ask questions
- start activities independently
- listen to instructions
- Slow to perform tasks
- Able to remember information, instructions?
- Able to organise self

- Does your child enjoy tasks such as puzzles, games and tasks that require attention and problem solving skills? Yes/No
- Do they tire easily during periods of attentional activity or classroom activities? Yes/No

Any Other Observations _____

Financial Responsibility

I hereby agree to accept full responsibility for all fees for services rendered by the practitioners at *Ask A Speechie*.

Signed: _____ Date: _____

Cancellation Policy

Ask A Speechie is dedicated to providing quality services to our clients. We must stress that:

- Consistency of attendance is crucial in order for clients to effectively meet the goals of their treatment plan.
- In addition, therapy time is specifically reserved for your family and is unavailable for other clients.

We are sensitive to the needs faced by the families of our clients however it is necessary for us to reinforce a cancellation policy.

A fee of \$50 fee will be charged if cancellation is not completed 24 hours prior to the appointment. No cancellation fee applies if 24 hours notice is given.

We look forward to a positive relationship with you, as we strive to provide cutting edge, quality therapy and specialized programs. Thank you for your attention to this matter.

Signed: _____ Date: _____