CHILD CASE HISTORY FORM

speechcare
Speech pathologists who care

Client Name:	Date of Birth:	Age:
Names of siblings: 1)	Date of Birth:	Age:
2)	Date of Birth:	Age:
Parents Names:		
Mobile phone:	Home phone:	Work phone:
Email address:		
Postal address: State: Post code:		
Do you have private health insurance? ☐ Yes ☐ No	Name of fund:	

How did you hear about us? ☐Google ☐Website ☐ Yellow pages ☐Walk in ☐Family/ Friends

☐GP/ Specialist (name): ☐Other (please specify):

What was the main reason for this referral? (please tick)

☐ Speech/ pronunciation of sounds ☐ Stuttering ☐ Literacy

☐ Understanding of Language ☐ Use of Language ☐ Voice

☐ Other:_____

Family History (please tick)

☐ Speech difficulties ☐ Language difficulties ☐ Reading /Spelling difficulties ☐ Stuttering

If yes to any of the above please give details:

Do you speak a language other than English at home? *If yes please specify*: _____ ☐ Yes ☐ No

Developmental History

Were there any difficulties during the pregnancy or birth? ☐ Yes ☐ No

If yes please specify:

Were there any feeding difficulties during infancy? ☐ Yes ☐ No

If yes please specify:

Was your child late to achieve motor milestones (sitting up, crawling, walking etc)? ☐ Yes ☐ No

If yes please specify:

Was your child late to achieve language milestones? ☐ Yes ☐ No

If yes please specify:

Medical History

Are there any diagnosed illnesses/ disorders? ☐ Yes ☐ No

If yes please provide details:

Has your child had recurrent middle ear infections? ☐ Yes ☐ No

If yes please provide details:

Has your child's hearing been tested? ☐ Yes ☐ No

If yes please provide details/ dates

Educational History

Please select you child's educational level? ☐Pre-prep ☐Prep ☐Primary ☐Middle ☐High School ☐College

Please provide details of school/ teacher:

Is your child experiencing any difficulties at school? ☐ Yes ☐ No

If yes please provide details:

Social History

Does your child experience any difficulty relating to other children or adults? ☐ Yes ☐ No

If yes please provide details:

Previous Intervention

Has your child ever been assessed by a Speech Pathologist or received speech therapy? ☐ Yes ☐ No

If yes please provide details:

Has your child been assessed by a medical or other allied health professional (Psych, Physio, OT)? ☐ Yes ☐ No

If yes please provide details:

Consent to Treatment –Client Information

I understand that if I have any questions or concerns regarding my child's treatment, I should discuss them with the Speech Pathologist before signing this consent.

I understand that at times, it is important for my child's clinical information to be shared with other relevant Professionals, such as a GP, a referring Specialist or an Allied Health Professional.

I understand that a minimum of 24 hours notice is required for appointment changes or cancellations and that those appointments cancelled or changed with less than 24 hours notice may incur a $40.00 fee.

I give my consent to treatment and I give my consent to the release of clinical information to other relevant Professionals if required.

The information I have provided is correct and complete.

Parent/Legal Guardian:

Signed: _____ **Date:** _____

Thank you for taking the time to complete this form.