

Stirling Speech Pathology has been contracted to provide services on behalf of the Child Development Service

## CASE HISTORY FORM

*(Please circle the correct responses where appropriate)*

### GENERAL INFORMATION

Child's Name: \_\_\_\_\_ M / F

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Email Address: \_\_\_\_\_

Does the child live with both parents? YES NO

Mother's Name: \_\_\_\_\_

Mother's Occupation: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Father's Name: \_\_\_\_\_

Father's Occupation: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Siblings: Name: \_\_\_\_\_ M / F Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_ M / F Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_ M / F Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_ M / F Date of Birth: \_\_\_\_\_

Others (add here): \_\_\_\_\_  
\_\_\_\_\_

Language/s spoken at home: \_\_\_\_\_

### OTHER PROFESSIONALS INVOLVED IN YOUR CHILD'S MANAGEMENT

Name: \_\_\_\_\_ Profession: \_\_\_\_\_

Contact details: \_\_\_\_\_

Name: \_\_\_\_\_ Profession: \_\_\_\_\_

Contact details: \_\_\_\_\_

**BACKGROUND INFORMATION**

Pregnancy and birth history

Were there any concerns during the pregnancy? YES NO

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Were there any problems during and immediately after the birth? YES NO

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medical history

Has the child undergone any medical treatment for significant injuries or illnesses? YES NO

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has your child suffered any middle ear infections? YES NO

If yes, how often, what age was your child and how were they treated? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has your child had grommets inserted at any stage? YES NO

If yes, when and how many times? \_\_\_\_\_  
\_\_\_\_\_

Has your child's hearing been tested recently? YES NO

If yes, when was the test and what were the results? \_\_\_\_\_  
\_\_\_\_\_

Are there any concerns about your child's physical development? YES NO

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

Motor milestones

When did your child reach the following milestones (approximately)?

Sitting: \_\_\_\_\_ Crawling: \_\_\_\_\_ Walking: \_\_\_\_\_

Is your child able to:

Feed him/herself?	YES	NO	SOMETIMES
Dress him/herself?	YES	NO	SOMETIMES
Toilet him/herself?	YES	NO	SOMETIMES

**SPEECH AND LANGUAGE INFORMATION**

What are your concerns about your child’s speech and language? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

When was the problem first noticed and by whom? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Has there been any change in your child’s speech and language performance since it was first noticed? YES NO

If yes, please describe: \_\_\_\_\_

Is the child aware of the problem? YES NO NOT SURE

If yes, how do you know? \_\_\_\_\_

What age (approximately) was your child when he/she

- Said single words \_\_\_\_\_
- Put two words together \_\_\_\_\_
- Used simple sentences \_\_\_\_\_
- Asked simple questions \_\_\_\_\_

Have any concerns about your child’s understanding/comprehension of speech? YES NO

Family history

Is there a family history of:

Speech/language problems? YES NO NOT SURE If yes, who? \_\_\_\_\_

Hearing problems? YES NO NOT SURE If yes, who? \_\_\_\_\_

Literacy problems? YES NO NOT SURE If yes, who? \_\_\_\_\_

Psychological problems? YES NO NOT SURE If yes, who? \_\_\_\_\_

Learning problems? YES NO NOT SURE If yes, who? \_\_\_\_\_

Have you sought help for your child's speech/language problems previously? YES NO

If yes, by whom? \_\_\_\_\_

Would you describe your child's voice as too loud or too soft? Describe: \_\_\_\_\_

Does your child speak with an unusual voice quality? YES NO

If yes, describe: \_\_\_\_\_

Does he/she snore while sleeping? YES NO OCCASIONALLY

Does your child speak too fast or too slowly? Describe: \_\_\_\_\_

Does your child repeat sounds or words or hesitate when talking? YES NO

### **SOCIAL/BEHAVIOURAL HISTORY**

What kind of play or playthings does your child enjoy the most? \_\_\_\_\_

\_\_\_\_\_

Can your child amuse himself alone? YES NO

Does he/she play well with other children? YES NO SOMETIMES

Does your child relate well to adults? YES NO SOMETIMES

Is your child unusually active? YES NO

Does your child have difficulty concentrating? YES NO

Do you have trouble disciplining your child? YES NO

If yes, please explain more \_\_\_\_\_

\_\_\_\_\_

### **EDUCATIONAL HISTORY**

Does your child attend **Day Care**? YES NO If yes, which one? \_\_\_\_\_

Does your child attend **Kindergarten**? YES NO If yes, which one? \_\_\_\_\_

Which days? \_\_\_\_\_ Teachers name: \_\_\_\_\_

Does your child attend **Pre-primary**? YES NO If yes, which one? \_\_\_\_\_

Teachers' name/s: \_\_\_\_\_

Does your child attend **school**? YES NO If yes, which school? \_\_\_\_\_

What year is your child in? \_\_\_\_\_ Teachers' name/s: \_\_\_\_\_

Does the school have any concerns regarding your child? YES NO

If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

Person/s completing this form: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_