speechcare
speech pathologists who care

CHILD CASE HISTORY FORM

Name: _____ Date of Birth: _____Age: _____

Preferred name (if different): _____

Outline specific identifiers (eg. pronouns) where preferred: _____

Parent/Guardian Names: _____

Preferred names (if different): _____

Outline specific identifiers (eg. pronouns) where preferred: _____

Siblings' names and ages:_____

Preferred phone number: _____

Alternate phone number: _____

Home address: _____

Postal address (leave blank if same): _____

5/876 Old Cleveland Road Carina 4152
07 3395 4400
admin@speechcare.com.au
ABN 85635256487

Email address: _____@_____

Parent/ Carer/ Next of Kin/ Emergency Contact (please circle those that apply)

Name: _____

Contact details: _____

Do you have private health insurance? Yes ☐ No ☐

Name of Fund: _____

Medical Practitioner/referring doctor (GP/Specialist): _____

Phone Number: _____

Address: _____

_____

Aboriginal or Torres Strait Islander? Yes ☐ No ☐

Do you speak a language other than English at home? Yes ☐ No ☐

If yes, please specify: _____

How did you hear about us?

☐ Google/Website ☐ GP/Specialist Referral ☐ Family/ Friends ☐ Other_____

Referral Information

Reason for referral:

☐ Stuttering ☐ Voice ☐ Language (Understanding) ☐ Language (Expressing)

☐ Literacy ☐ Swallowing /Mealtimes ☐ Social Communication/Play ☐ Speech difficulties

☐ Other (*please specify*): _____

Notes:

Medical and Developmental History - ***Please provide copies of relevant medical reports.***

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

If yes, please provide details

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

If yes, please provide details

Was your child late to achieve speech/language/play/friendship milestones? Yes ☐ No ☐

If yes, please provide details

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

If yes, please provide details

If there a history in your family of speech, language, feeding, social communication or other difficulties related to your concern, please provide details.

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

Is there a history of middle ear infections/known or suspected hearing loss? Yes ☐ No ☐

P*lease provide latest results and date of hearing test*

Educational Details

Current Educational Setting and Year Group:

School/ teacher:

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

If yes, please provide details-

Previous Intervention

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

If yes, please provide details-

Has your child been assessed by another allied health professional ie Psychologist, Physiotherapist, Occupational Therapist? Yes ☐ No ☐

If yes, please provide details-

Consent to Treatment – Client Information

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

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

I understand that a minimum of 24hours notice is required for appointment changes or cancellations and that those appointments cancelled or changed with less than 24hours notice may incur a $50.00 fee.

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

The information I have provided is correct and complete.

Name: _____ **Signed:** _____

Date: _____

Thank you for taking the time to complete this form.

Clinician Notes

Assessments, Intervention Plan (frequency/duration), further information required