0451 692 468
PO Box A220 ARNCLIFFE NSW 2205
admin@tellmeall.com.au
www.tellmeall.com.au

Tell Me All About It
SPEECH PATHOLOGY

Case History Form

General Information

Today's Date					
Client Name		**DOB**		**Age**	
Person Completing Form's Name		**Relationship to Client**			
Parent's Occupation(s)					
Phone		**Email**			
Address					
Suburb		**Postcode**			

Medical History

Circle/highlight all that apply.

Tonsilitis	Frequent colds	Vision problems
Adenoidectomy	Seasonal allergies	Wears glasses
Tonsillectomy	Nasal congestion	Head injuries
Difficulty sleeping	Chronic ear infections	Allergies (list)
Snoring	Hearing loss	Other medical/genetic diagnosis(es) (list)
Breathing difficulties	Ear (PE) tubes	

Additional medical information (surgeries, hospitalisations, medications, etc):

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Date of last hearing screen __________ **Location** ____________________

Results ☐ Pass ☐ Fail

Date of last vision screen __________ **Location** ____________________

Results ☐ Pass ☐ Fail

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Feeding/Eating History

Circle/highlight all that apply.

Thumb/finger sucking	Messy eater	Food allergies
Pacifier use	Limited diet	Weight issues
Difficulty nursing	Food texture sensitivity	Picky eater
Reflux/Colic	Drooling observed	Choking/coughing while eating
Tongue thrust	Tongue or lip tie present	Sensitive gag reflex

If you checked any of the above, please provide further detail

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Was your child ☐ Bottle Fed ☐ Breastfed **For how long?** ____________________

Does your child primarily breathe through their ☐ Nose ☐ Mouth ☐ Unsure

Does your child snore? ☐ No ☐ Yes

Developmental History

Indicate the approximate age at which your child reached the following milestones.

Sat alone	____________	Walked	____________	Grasped crayon/pencil	____________
Crawled	____________	Toilet trained	____________	Began to scribble/draw	____________

Do you consider any physical/motor milestones to be delayed or impaired? ☐ No ☐ Yes

If yes, please describe.

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Presentation (other)

Circle/highlight all that apply.

Unusually active/fidgety	Low muscle tone	Clumsy
Easily overwhelmed	Overly sensitive to sound	Overly sensitive to touch

If you checked any of the above, please describe.

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Has your child been diagnosed with a developmental disability or behavioural disorder? ☐ No ☐ Yes

If yes, please specify.

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Education and Additional Services

Does your child attend school, preschool or day care? ☐ No ☐ Yes

Facility Name ______________________ **Grade** __________

Teacher's Name ______________________

Does your child have an active ILP or IEP? ☐ No ☐ Yes

If yes, does your child receive any regular services? Which? __________________

Does your child receive any other therapies or intervention? ☐ No ☐ Yes

If yes, please list them. ______________________________

____

____

Has your child ever received speech pathology evaluation/therapy? ☐ No ☐ Yes

If yes, when and by whom? ______________________________

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Does your child know how to read? ☐ No ☐ Yes

Does your child have difficulty reading? ☐ N/A ☐ No ☐ Yes

Does your child have difficulty with a particular subject? ☐ N/A ☐ No ☐ Yes

If yes, which subject(s)? ____________________

Has your child ever repeated a grade? ☐ N/A ☐ No ☐ Yes

If yes, which grade and why? ____________________

Is your child receiving any other help at school/home (e.g., tutoring) ☐ No ☐ Yes

If yes, please list. ____________________

Speech and Language Development

Indicate the approximate age at which your child reached the following milestones.

Babbled	____________	Put two words together	____________
Said first words	____________	Spoke in short sentences	____________

Was your child a quiet infant (limited vocalisations/babbling)? ☐ No ☐ Yes

Did your child produce consonant sounds in babbling by 12 months?
(e.g., “mmm”) ☐ N/A ☐ No ☐ Yes

Did your child produce consonant + vowel syllables by 18 months?
(e.g., “doo”, “bah”, “no”) ☐ N/A ☐ No ☐ Yes

Did your child produce /k/ or /g/ sounds in their babbling?
(e.g., “goo”, “gah”, “kah”) ☐ N/A ☐ No ☐ Yes

Did your child have 5 or more consonant sounds at 2 years old? ☐ N/A ☐ No ☐ Yes

Did your child prefer to use /m/, /p/ or /b/ sounds over others? ☐ No ☐ Yes

Does your child communicate with ☐ gestures ☐ words ☐ both ☐ neither

Does your child:
Circle/highlight all that apply. If any options are not selected, please provide details.

Follow simple directions?	Follow complex or multi-step directions?	Ask questions during conversation?
Understand what you are saying?	Identify objects and actions easily?	Respond correctly to yes/no questions?

Is your child's speech understood by most people? ☐ N/A ☐ No ☐ Yes

If any options above are not selected, or your child has difficulties being understood, please elaborate.

Is your child aware of or frustrated by any communication difficulties? ☐ No ☐ Yes

Please provide some examples of a typical sentence or utterance your child says.

What are your specific concerns regarding your child's communication?
Circle/highlight all that apply.

Speech sounds / articulation	Receptive language (e.g., following instructions)	Expressive language (e.g., sentence structure, grammar)	Literacy (spelling/reading/writing)
Social/play skills	Voice quality	Fluency (stuttering)	"Picky" eating

Other (please describe) ____________________

How did you hear about us?

Referral   Search engine (e.g., Google)   Social media (e.g., Facebook)   Word of mouth

Other ____________________

Preferred day(s) for therapy

Monday   Thursday   Friday   Saturday