Case History

Date: __________________

Person completing this form: ____

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

General Information

CHILD'S NAME:__________________________ **Date of Birth:** ___________________

Address:________________________________

School: ________________________________ **Grade:** _______________________

MOTHER'S NAME:____________________ **Mobile phone:**______________________

Mother's occupation:___________________ **Email:**__________________

FATHER'S NAME:_____________________ **Mobile phone:**_______________________

Father's occupation:____________________ **Email:**___________________

Are there any court orders in place? Yes/No

If yes, do you have a copy? Yes/No

Referred by:_________________________________

Paediatrician/Primary Doctor:_____________________ **Phone:**____________________

Description of the problem:
____
____
____
____

Are you NDIS registered? Yes/No

If yes, are you plan or self-managed? __________________

If plan managed who is your agency? Please provide email contact for invoicing? ________________________________

What is the end date of your NDIS plan? _________________________

Medical History

Mother's general health during pregnancy – please describe (illnesses, accidents, medications, mental health challenges etc). Please describe any complications during pregnancy and/or delivery:____
____
____

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

Food Allergies: **Ear infections:** **Frequent Colds:**

Colour blindness: **Headaches:** **High fever:**

Influenza: **Seizures:** **Sinusitis:**

Tonsillitis: **ADD/ADHD:** **Snoring:**

Asthma: **Autism Spectrum Disorder: 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 hospitalisations:
____
____
____

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:

Babble: **Roll over:** **Crawl:** **Sit:** **Walk:** **Feed self:**

Use the toilet:

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

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

Engage in conversation:

Does your child have difficulty walking, running, or participating in other activities which require small or large muscle coordination?

____
____

Are there or have there been any feeding or eating problems (e.g., any problems with sucking,tolerating specific food textures, swallowing, drooling, chewing, etc.)? If yes, please describe.

____
____

Educational History

Did / does your child attend preschool or primary school? Where, how many days/week, full/half days?

____
____

Has his/her teacher reported any concerns to you? Please describe.

____
____
____

Does your child like school?

____
____

Does your child receive any specialised support at school for reading, writing or general academics?

____
____
____

Social History

Does your child live with both parents?_______________

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

Relationship to child? ____

Siblings (include names and ages):_____________________________________

Is English your child's primary language? Y / N

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?____

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

How does your child interact with others (e.g., shy, comfortable, outgoing, aggressive, inflexible, etc.)?____

Do you have any concerns about your child's social skills or ability to make/keep friends? Please describe.____
____

Previous Testing and Therapeutic Intervention

Please list other professionals currently involved with your child's care (Psychologist, Neurologist, Speech Language Pathologist, Occupational Therapist, Ear Nose Throat Doctor, tutors etc.)
____
____
____

Please indicate if your child has had their hearing and vision assessed. If so, when was the testing completed and what were the results?____
____

Please indicate your child's strengths and interests:
____
____
____

Child Checklist:

To assist us in gaining a complete profile of your child's strengths and challenges, please check off any areas outlined below that may apply:

Listening:

___Has trouble paying attention.

___Has trouble following spoken directions.

___Has trouble remembering things people say.

___Has to ask people to repeat what they have said.

___Needs extra time to respond to questions.

Attention:

___Often has difficulty sustaining attention in tasks or play activities in school and at home.

___Has difficulty organizing tasks and activities.

___Often loses things necessary for tasks and activities (e.g., toys, school assignments,pencils, books, or tools).

___Fidgets with hands or feet or squirms in seat.

Speaking:

___Has trouble answering questions people ask.

___Has trouble asking questions.

___Has trouble using a variety of vocabulary words when talking.

___Has trouble getting to the point when talking.

___Uses poor grammar when talking.

Word Retrieval:

___Knows the word (s)he wants to say, but cannot think of it.

___Has difficulty remembering the names of people, places, objects that (s)he knows.

___Uses time fillers when trying to think of a word (e.g., um…er…um…computer).

Social Communication:

___Decreased eye contact when interacting with others.

___Frequent conflicts with peers are noted by others such as teachers, scout leaders, etc.

___Avoids or shows no/little interest in social interactions of same age peers, such as birthday parties.

___Needs to be directly taught "implied social rules," such as keeping personal space, responding to others when they talk or greet them, how to talk to adults/authority figures vs. peers, messages sent by their tone of voice.

___Has trouble staying on the subject when talking.

Reading:

___Has trouble sounding out words when reading.

___Has trouble understanding what was read.

___Has trouble explaining what was read.

Writing:

___Has trouble writing down thoughts.

___Writes short, choppy sentences.

___Has trouble expanding an answer or providing details when writing.

___Has trouble putting words in the right order when writing sentences.

I ______________________ (parent/guardian name) consent for S.M.A.R.T Spot Education and Therapy Services to assess my child and also provide intervention where discussed.

Signature:________________

Date of Consent Given: __________________