



Now We're Talking - 0417246867
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Case History Form

General Information

Client's Name: _____ Date of Birth: _____

Age: _____ Client's School/ Kinder: _____

Parent/ Guardian names: _____

Primary contact number: _____

Email: _____

Preferred (please circle as many as you would like): Email / Text message / Phone call

Home Address: _____

Suburb: _____ Post Code: _____

Who referred you to 'Now We're Talking'? _____

Who lives at home? (If siblings include names and ages)

Supports outside of home:

Languages spoken at home? What is the primary language spoken?

What do you as the carer want help with for the client?

When was the difficulty first noticed?

Has the difficulty changed since it was first noticed?

Is the client aware of the difficulty? If yes, how do they feel about it?

Has the client seen a Speech Pathologist before? If so, when? (If no, skip next question)

What were the conclusions or suggestions made? (if possible, please provide us with the reports/ any documentation)

Have any other specialists (physicians, OT's, psychologists, etc.) assessed or treated the client? If yes, indicate the type of specialist, when the client was seen, and the specialist's conclusions or suggestions. (if possible, please provide us with the reports/ any documentation)

What are the client's strengths?

What does the client really enjoy doing?

Medical History

Please indicate if the client has had, or now has any of the following:

Allergies_____Asthma_____Heart concerns_____

Seizures_____Ear Infections_____Headaches_____

Epilepsy_____Other_____

Does the client have any official diagnoses? If yes, please list below:

Has the client had any surgeries? If yes, what type and when (e.g., tonsillectomy, adenoidectomy, etc.)?

Please list any major accidents or hospitalizations:

Is the client taking any medications? If yes please identify.

Speech Pathology

Articulation (speech sounds) Age appropriate Further development required

Comments:

Receptive Language (listening) Age appropriate Further development required

Comments:

Expressive Language (talking) Age appropriate Further development required

Comments:

Milestones- If you are not sure of the date please do your best to provide a calculated guess!

First babble: _____ First word: _____

First put words together: _____

Any concerns with swallowing? Yes No

Any concerns with the quality of their voice? Yes No

Any concerns with stuttering? Yes No

Any concerns with food aversion? Yes No

Had the client lost all of their teeth? Yes No

Does the client have glasses or hearing aids? Yes No

Occupational Therapy

Self-care (sleeping, eating, toileting) Age appropriate Further development required

Comments:

Play skills Age appropriate Further development required

Comments:

Gross and fine motor skills

Age appropriate

Further development required

Comments:

Milestones- When did they first: Sit: _____ Crawl: _____ Walk: _____

Does the client have any behavioral concerns?

Comments:

Does the client have any Sensory preferences?

Hearing

Has the client ever had a hearing test? _____

Results: _____

Educational History

Year at Kindergarten/ Grade at school: _____

How do you feel the client is progressing academically?

Does the client receive as supports at school or kindergarten?

Does the client interact well with others? (e.g., shy, aggressive, uncooperative, etc.)

Provide any additional information that you feel would be helpful or needs to be taken into consideration:

Person completing form: _____ Relationship to client: _____

Signed: _____ Date: _____

Thank you for completing this case history form. 😊