



CASE HISTORY QUESTIONNAIRE

DATE: _____

CLIENT'S NAME: _____ D.O.B.: _____

CLIENT'S AGE: _____

PARENTS' NAMES: (if client is a child) _____

ADDRESS: _____

TELEPHONE:
(Home) _____ (Business) _____

(Mobile) _____ E-mail: _____

Do you have Private Health Insurance? (Name of Fund): _____

Were you referred to this clinic? _____ By Whom? _____

What was the main reason for this referral? _____

How did you choose this clinic? (Please tick)

Medical Referral

Web Site

Yellow Pages Book

Advertisement: Please specify _____

Yellow pages On-line

Other: _____

Head Office: 65 Wentworth Pde Balmoral 4171 Ph. (07) 38991081 Fax: (07) 38990267
e-mail: speechcare@optusnet.com.au

Carindale Office: Medical Specialists' Centre, Carindale Shopping Centre, Creek Rd, Carindale 4152.
Ph (07) 33989798

Communication Enrichment Services Pty. Ltd. (ACN 073 395 801) trading as
Speech Care, under licence from Shepley Discretionary Trust

FAMILY HISTORY

Other children in the family?	Name	Date of Birth

Is there a history in your family of:

Speech difficulties?	YES / NO	Fluency difficulties?	YES / NO
Language difficulties?	YES / NO	Reading /Spelling difficulties?	YES / NO

If yes to any of the above please give details: _____

Do you speak a language other than English at home? YES / NO

DEVELOPMENTAL HISTORY

Were there any difficulties during the pregnancy or birth? YES / NO
Were there any feeding difficulties during infancy? YES / NO
Was your child late to achieve motor milestones (sitting up, crawling, walking etc)? YES / NO
Was your child late to achieve language milestones? YES / NO

If yes to any of the above please give details: _____

MEDICAL HISTORY

Are there any diagnosed illnesses/ disorders? YES / NO
Has your child been hospitalised? YES / NO
Has your child had recurrent middle ear infections? YES / NO
Has your child's hearing been tested? YES / NO Date and results: _____

If yes to any of the above please give details:

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EDUCATIONAL HISTORY

What is your child's educational level? Pre prep / Prep / Primary / Middle / High School

Please provide details of school, year level and teacher's name: _____

Is your child experiencing any difficulties at school? YES / NO

If YES please provide details: _____

SOCIAL HISTORY

Does your child experience any difficulty relating to other children or adults? YES / NO

If YES please provide details: _____

PREVIOUS INTERVENTION

Has your child ever been assessed by a Speech Pathologist or received speech-language therapy? YES / NO

If YES please give details (name of speech pathologist, period of intervention):

Has your child ever been assessed by a medical specialist or other allied health professional (eg Occupational Therapist, Physiotherapist, Psychologist, Audiologist)? YES / NO

If YES please provide details: _____

Thank you for taking the time to complete this questionnaire.
Please return to Speech Care at the address below.

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