

**CASE HISTORY  
PAEDIATRIC**

Name:	Date:
DOB:                      Age:	Referred by:
Address:	Relationship:
Other professionals (please state when and why) GP: Paediatrician: Physiotherapist: Ear, Nose & Specialist: Occupational Therapist:	Speech Pathologist: Psychologist: Psychiatrist: Learning support: Optometrist: Other:
Parents/Carers:	
Phone Home:	
Phone Work:	
Phone Mobile:	
Email:	Health Fund:
Ethnicity:	School: Year:
Languages/ spoken at home:	Teacher:

**Parent's Concerns**

**School's Concerns**

**Your child's strengths/interests/favourite activities/habits**

## Speech and Language History & Motor Development

When did your child do the following (approximately):

Sit alone	_____ months	Babbling	_____ months
Crawling	_____ months	1 <sup>st</sup> words	_____ months
Walking	_____ months	Say 2 words together	_____ months
Toileted	_____ months	Know & use 50 different words	_____ months

## Pregnancy, Birth Details & Infant Details

Term (weeks):

Birth weight:

Delivery:

Illness / complications:

Did your child have difficulty with:

- Early feeding Yes / No  
(e.g. sucking, swallowing, reflux, vomiting)
- Nursing or taking a bottle Yes / No
- Transitioning from baby food Yes / No
- Tolerating a variety of food textures Yes / No

Other comments:

## Medical & Hearing History

Ear infections? Yes / No	How frequent?	
Hearing test? Yes / No	When?	Result?
Vision test? Yes / No	When?	Result?

Current Medications and Allergies:

Serious illnesses (head trauma, seizures) or Diagnoses (ASD, ADHD):

Hospitalisation / Surgery (tonsils, adenoids, grommets):

## Family History

Is there a family history of hearing, attention, learning, attention, stuttering or behaviour difficulties?  
If yes, please describe (immediate and extended family):

## School history

	Years	Name of School
Preschool		
Primary School		
High School		

Has your child ever repeated a year? Yes / No What year?  
Reason:

Does your child receive learning support? Yes / No At school / out of school  
When? Duration? Service provided?

In your opinion, what is your child's current achievement at school in the following areas:

	ABOVE AVERAGE	AVERAGE	BELOW AVERAGE
Reading accuracy			
Reading comprehension			
Reading Fluency			
Spelling			
Written expression			
Oral/verbal expression			
Handwriting			
Mathematics			
Science			
Art and Design.			

## Communication Skills

**Does your child have any of the following difficulties:**

- understanding questions Yes / No
- following instructions Yes / No
- understanding sarcastic comments Yes / No
- understanding stories Yes / No
- speaking in sentences Yes / No
- using clear precise language to express him/herself Yes / No

## Participation and Life Skills

**Does your child have any of the following difficulties? Please explain:**

- Completing activities (e.g. avoids trickier tasks, maintaining attention to activities, moves around a lot, following routine, following directions, often tired, easily distracted, finishing tasks, homework, fidgets)
- Handwriting skills (e.g. pencil grasp, forming letters, reversals, legibility, speed, pain, written organisation, generating ideas)

- Self care skills (e.g. managing belongings, buttons, shoelaces, using cutlery)
- Gross motor skills (e.g. running, appears un-coordinated, ball skills)
- Social Behaviour (e.g. playing with and making friends, sharing, turn-taking, controlling emotions)

Is there any other information you would like to tell us about?

Thank you for completing our questionnaire. Please scan, return document or take clear photos and email to [admin@sydneytherapy.com.au](mailto:admin@sydneytherapy.com.au)

Signed:

Name:

Date: