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:

_____
_____
_____
_____

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/Did your child ever use a pacifier/suck thumb or have an attachment to any other objects they put in their mouth? Yes / No If yes, when, how often and under what conditions?

_____
_____

When did (s)he discontinue using the pacifier/sucking the thumb?

_____
_____

How does your child primarily communicate (gestures, single words, short phrases, sentences, conversation)? Please circle.

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.

_____
_____

From what does your child primarily drink? (e.g. cup, straw, sippy cup, bottle). Please circle.

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.

_____
_____
_____

How is your child doing academically (or pre-academically)? Please comment on reading and written language.

_____
_____
_____

Does your child like school?

_____
_____

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

_____
_____
_____

Does your child receive Speech Therapy at school?

_____
_____

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:

Auditory Processing:

___Does not listen carefully to directions - often need to repeat instructions.

___Sometimes misunderstands what is said.

___Needs extra time to respond to questions.

___Background noise makes following verbal instructions even more difficult.

___Says "huh" or "what" in response to questions.

Listening:

___Has trouble paying attention.

___Has trouble following spoken directions.

___Has trouble remembering things people say.

___Has trouble understanding what people are saying.

___Has to ask people to repeat what they have said.

___Has trouble understanding new ideas.

Attention:

___Often fails to give close attention to details or makes careless mistakes in schoolwork, work,or other activities.

___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.

___Leaves seat in classroom or in other situations in which remaining seated is expected.

___Has difficulty awaiting turn.

___Daydreams and/or is inattentive.

Speaking:

___Has trouble answering questions people ask.

___Has trouble asking questions.

___Has trouble using a variety of vocabulary words when talking.

___Has trouble expressing thoughts.

___Has trouble describing things to people

___Has trouble getting to the point when talking.

___Uses poor grammar when talking.

___Has trouble using complete sentences when talking.

___Has trouble having a conversation with someone.

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.

___There is sometimes a long delay when (s)he cannot think of the word.

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

___Gives too much information, includes irrelevancies

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.

___Has trouble identifying the main idea.

___Has trouble remembering details.

___Has trouble following written directions.

Writing:

___Has trouble writing down thoughts.

___Uses poor grammar when writing.

___Has trouble writing complete sentences.

___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: _____