



not all talk
SPEECH PATHOLOGY

Educate... Empower... Engage

***Please complete this form and return to the clinician
before your child's assessment. (chantelle@notalltalk.com.au)***

CASE HISTORY

Full name (as to appear on report and for Medicare claiming, if appropriate):

Information gathered from: (person completing the form) _____

D.O.B/Age: _____

Reason for referral: _____

Source of referral: _____

Siblings and ages: _____

Does your child have a current diagnosis? NO YES (detail) _____

**Has your child ever seen a SP before? If yes, provide details re: name of therapist, year
accessed and summary of goals:** _____

**Is a language other than English spoken at home? If yes, please detail which language
student understands and uses best:** _____

Family history of communication disorders: _____

Feeding History:

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-
- Problems chewing _____
 - Drooling _____
 - Thumb sucking NO YES
 - Dummy NO YES (age when stopped: _____)

Language Milestones:

- Babbling NO YES (Example and age of onset) _____
- First Words at (age and example) _____
- Sentences at (age and example) _____

Medical History:

- Allergies/ Illnesses/injuries _____
- History of ear infections? NO YES
If yes, were these treated with antibiotics? _____
- Regular Medications _____
- Any facial abnormalities at birth: Tongue tie, cleft lip or palate? NO YES
If yes, when and where repaired? _____

Are there any professionals currently working with your child?

- GP: _____
- Specialist and allied health: _____



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Audiology:

- **Has a formal hearing assessment been conducted?** NO YES

If yes, when? (date) _____

If yes, what was the result? (findings) _____

Vision:

- **Has a formal vision assessment been conducted?** NO YES

If yes, when? (date) _____

If yes, what was the result? (findings) _____

What are your concerns re: speech/ language/ communication? Please include description of problem and any impact on current school/ /family/peer interactions:

When were you first concerned about your child's speech/language/communication?
