



Lynne Middleton, Speech Pathologist, B. Appl. Sc. Speech Pathology, MSPA, MPSPAWA, Provider Number 2616901L

Hanen Certified for the Programs: It Takes Two to Talk, More than Words, Talkability, ABC and Beyond and Target Word.

Talk to Literacy "Thody House" 20 Craig St., Mundaring 6073 Ph 9295 3836 Fax 9295 0830  
talktoliteracy@gmail.com www.talktoliteracy.com.au ABN 90397 615 648

### Speech Pathology Case History Sheet

Child's Full Name:

Date of Birth:

Address:

Home Phone:

Mother's Name:

Occupation:

Email Contact:

Mobile Phone Number:

Father's Name:

Occupation:

Email Contact:

Mobile Phone Number:



Please Outline What you are Concerned about with regard to your Child's Speech/Language/Literacy/Social Communication Challenges.



What do you hope to get out of the assessment session?



What are your child's favourite things to do and to play with?



Is there anything he/she really dislikes?



Please state when your child said his/her first word

Is he/she combining words together?

When did he/ she sit?.....crawl?.....walk?.....

Is he/she toilet trained? If so at what age was he/she dry during the day..... at night?

Is your child able to eat a variety of solid foods with different textures?



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Describe who lives at home with your child.



Are there any custody arrangements in place?



Has anyone in the family had a speech/language or learning difficulty?  
difficulty and whether they received speech therapy.

If so, please describe the type of



Has your child had a recent hearing test? If so, when?  
What were the results?



Has your child seen another speech pathologist? If so, who and when?



Are you happy for your child to receive speech therapy if the assessment indicates it is needed and would you be  
willing to be involved in the speech therapy program?



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Are you happy for Lynne to contact other professionals who have been involved with your child if she feels it would benefit his/her therapy outcome? Please circle whether you are happy for Lynne to contact the following people below:

Your Child's Doctor: Yes/No

Your Child's Health Nurse: Yes/No

Your Child's Day Care Provider: Yes/No

Your Child's Teacher: Yes/No

The School Psychologist: Yes/No

Grandparents: Yes/No



Signed:.....

Date:

If applicable, What is the school your child attends:

What class is he/she in?

What is his/her teacher's name?

Thanks so much for your time. This information will assist me when planning sessions.

Regards,

*Lynne Middleton*