Speech and Language Case History Form

Identifying information:

Child's Name:	**Home Phone:**
Sex: ❑ M ❑ F D.O.B	**Father's Name:**
Address:	**Father's Phone:**
City: Zip:	**Father's Email:**
Mother's Name:	**Doctor's Name:**
Mother's Cell:	**Doctor's Phone:**
Mother's Email:	**Doctor's address:**

How/from whom were you were referred?

_____

Child lives with (check one):
❑ Birth Parents ❑ Adoptive Parents
❑ Foster Parents ❑ One Parent
❑ Parent and Step-parent
❑ Other_____

Other children in the family:

Name	Age	Sex	Grade	Speech/hearing problems?

Child's race/ethnic group:
❑ Caucasian, Non-Hispanic ❑ Hispanic ❑ Native American ❑ Asian or Pacific Islander
❑ African-American ❑ Other _____

Is there a language other than English spoken in the home?

❑ Yes ❑ No If yes, which one?_____

Does the child speak the language? ❑ Yes ❑ No
Does the child understand the language? ❑ Yes ❑ No
Who speaks the language? _____
Which language does the child prefer to speak at home? _____

How would you describe your child as an infant (alert/active, difficult to calm, resistant or likes to be held, good or irregular sleep patterns, fussy or irritable, excessive crying, tense or floppy when held, responsive to surroundings)?
_____

Speech-Language-Hearing

Do you feel your child has a speech problem? ❑ Yes ❑ No
If yes, please describe. _____
_____
_____
Do you feel your child has a hearing problem? ❑ Yes ❑ No
If yes, please describe. _____
_____
_____
Has he/she ever had a speech evaluation/screening? ❑ Yes ❑ No
If yes, where and when? _____
What were you told? _____
_____
_____
Has he/she ever had a hearing evaluation/screening? ❑ Yes ❑ No
If yes, where and when? _____
What were you told? _____
_____
_____
Has your child ever had speech therapy? ❑ Yes ❑ No
If yes, where and when? _____
What was he/she working on? _____
_____
Has your child received any other evaluation or therapy (physical therapy, counseling, occupational therapy, vision, etc.)? ❑ Yes ❑ No
If yes, please describe._____

_____
_____
_____

Is your child aware of, or frustrated by, any speech/language difficulties?_____

_____

What do you see as your child's most difficult problem in the home?

_____
_____

What do you see as your child's most difficult problem in school?_____

_____

Birth History

Was there anything unusual about the pregnancy or birth? ❑ Yes ❑ No
If yes, please describe. _____

_____

_____

How old was the mother when the child was born? _____
Was the mother sick during the pregnancy? ❑ Yes ❑ No
If yes, please describe. _____

_____

How many months was the pregnancy?_____
Did the child go home with his/her mother from the hospital? ❑ Yes ❑ No
If child stayed at the hospital, please describe why and how long.

_____

_____

_____

Medical History

Has your child had any of the following?

❑ adenoidectomy
❑ allergies
❑ breathing difficulties
❑ chicken pox
❑ colds
❑ ear infections
How often?_____
❑ ear tubes
❑ encephalitis
❑ flu
❑ head injury
❑ high fevers
❑ measles
❑ meningitis
❑ mumps
❑ scarlet fever
❑ seizures
❑ sinusitis
❑ sleeping difficulties
❑ thumb/finger sucking habit
❑ tonsillectomy
❑ tonsillitis
❑ vision problems

Other serious injury/surgery: _____
Is your child currently (or recently) under a physician's care? ❑ Yes ❑ No
If yes, why?_____
_____

Does the child currently have a medical diagnosis? If so, please list/describe (please include history of chronic conditions, i.e. congestion/ear infections).
_____
_____
Does the child have any known allergies? (medications, foods, latex, seasonal, etc.)
Please list. _____
_____

Please list any medications your child takes regularly:
_____
_____
_____

Is there family history of speech, language, learning, hearing, sensory, motor or mental health issues (ADD, anxiety, etc.)? Describe.
_____
_____

Developmental History

Please tell the approximate age your child achieved the following developmental milestones:

_____ sat alone
_____ babbled
_____ put two words together
_____ walked
_____ grasped crayon/pencil
_____ said first words
_____ spoke in short sentences
_____ toilet trained

Does your child...

❑ choke on food or liquids?
❑ suck his/her thumb
❑ use a pacifier
❑ currently put toys/objects in his/her mouth?
❑ brush his/her teeth and/or allow brushing?

Current Speech-Language-Hearing

Does your child...

❑ repeat sounds, words or phrases over and over?
❑ understand what you are saying?
❑ retrieve/point to common objects upon request (ball, cup, shoe)?
❑ follow simple directions ("Shut the door" or "Get your shoes")?
❑ respond correctly to yes/no questions?
❑ respond correctly to who/what/where/when/why questions?

Your child currently communicates using...

❑ body language.
❑ sounds (vowels, grunting).
❑ words (shoe, doggy, up).
❑ 2 to 4 word sentences.
❑ sentences longer than four words.
❑ other _____.

Behavioral Characteristics:

❑ cooperative
❑ attentive
❑ willing to try new activities
❑ plays alone for reasonable length of time
❑ separation difficulties
❑ easily frustrated/impulsive
❑ stubborn
❑ restless
❑ poor eye contact
❑ easily distracted/short attention
❑ destructive/aggressive
❑ withdrawn
❑ inappropriate behavior
❑ self-abusive behavior

School History

If your child is in school, please answer the following:

Name of school and grade in school: _____
_____
Teacher's name: _____
_____
Has your child repeated a grade? _____
_____
What are your child's strengths and/or best subjects?
_____
_____

Is your child having difficulty with any subjects?
_____
_____
Is your child receiving help in any subjects? _____-
_____
_____

Reading/Writing History:

Does the child have interest in books? Describe. -
_____
_____
Describe the child's current literacy/writing status (reading, recognizing letters, tracing, etc.). _____
_____
_____

ADL/Self Help Skills:

Do you have any concerns with independent functioning? _____
Eating: Indicate yes/no, can the child...
Feed self finger food? _____
Bring spoon to mouth? _____
Cut food with knife?_____
Stab food with fork?_____
Scoop food with spoon? _____
Feed self independently?_____

Dressing: Indicate yes/no, Can the child independently...
Take off clothes (shirt, pants, shoes, socks, coat?)_____
Put on clothes (shirt, pants, shoes, socks, coat)?_____
Fasten small buttons, large buttons, or snaps?_____
Zipper up/down_____
Tie shoes?_____

Motor/Sensory Skills:
Do you have concerns regarding Gross Motor Skills (i.e. walking, jumping, running, balance, ball skills, physical activities)? If yes, describe.
_____
_____
_____

Has your child ever had difficulty with body awareness and/or coordination with movement (i.e. appears clumsy, grasps objects too light or too tight, moves very fast

or very slow, etc.)?_____
_____

Do you have concerns regarding Fine Motor Skills (i.e. holding pencil correctly, manipulation of objects, scissor skills, coloring within the lines)? If yes, describe.
_____
_____

Do you have concerns regarding your child's handwriting skills (i.e. poor spacing of words, reversals of letters/numbers, mastering cursive, etc)? If yes, describe._____
_____

Has your child ever had difficulty with sensory issues (i.e. respond differently to touch, noise, or smells; crave rough play or touch; bump into objects; not like to get messy; seem fearful of movement)? If yes, describe._____
_____
Does your child have difficulty staying focused/on-task as compared to same-age peers? If yes, describe.
_____
_____

Therapy Goals:
What are your current speech/language related goals/expectations for your child? Do you wish to pursue speech therapy if needed?
_____
_____

If yes, what are your preferred/available times to bring the child to therapy?
_____
_____

Are there any issues (language, religious, cultural, food restrictions, etc.) that may interfere with therapy? _____
_____

Additional Comments
_____
_____
_____
_____
_____
_____
_____