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CASE HISTORY INFORMATION

Child's Name: _____ Birthdate:_____ Sex:___M___F

Parent's Name: _____ Day Phone: _____

Address: _____ Cell Phone: _____

_____ Email: _____

How did you hear about our speech clinic? _____

Child lives with (check one):

___ Birth Parents ___ Foster Parents ___ One Parent
___ Adoptive Parents ___ Parent and Step-Parent ___ Other _____

Other children in family:

Name: Age: Sex: Grade: Any speech-hearing problem?

_____

_____

_____

_____

Is there a language, other than English, spoken in the home? ___ Yes ___ No

If yes, which language? _____

Does the child speak the language? ___ Yes ___ No
Does the child understand the language? ___ Yes ___ No

Which language does the child prefer to speak? _____

Has your child received any other evaluation or therapy for speech and language?
___ Yes ___ No

If yes, where and for how long? _____

Please send or bring any speech-language evaluations, IEP reports or other documents.

Has your child received any other evaluation or therapies (physical therapy, occupational therapy, counseling, etc.) ___ Yes ___ No

If yes, please describe _____

_____

Do you feel your child has a speech problem? ___ Yes ___ No

If yes, please describe _____

_____

Has your child's hearing been tested? ___ Yes ___ No

If yes, where and what were the results? _____

_____

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

___ Yes ___ No

Birth History

How old was the mother when the child was born? _____

Was the child born at full-term? ___ Yes ___ No

If no, how many weeks gestation? _____

What did the child weigh at birth? _____

Were there any unusual conditions or complications about the pregnancy or delivery?

___ Yes ___ No

If yes, please describe _____

_____

If the child did not go home from the hospital with his/her mother, please describe why and how long before he/she was released _____

_____

Medical History

Is your child currently under the a physician's care ___ Yes ___ No

Doctor's Name:_____ Phone number: _____

Has your child had any of the following:

___adenoidectomy
___allergies
Type:_____
___ chicken pox
___ colds
___ ear infections
How frequent?_____
___ breathing difficulties
___encephalitis
___flu
___head injury
___high fever
___ measles
___ meningitis
___ mumps
___ ear tubes
___ seizures
___ sinusitis
___ sleeping difficulties
___ thumb/finger sucking
___ tonsillectomy
___ tonsillitis
___ vision problems
___ scarlet fever

Other serious injury, illness, or hospitalization? _____

_____

Please list any medications that your child takes regularly: _____

_____

Developmental History

Please indicate the approximate age at which your child achieved the following milestones:

_____ sat alone
_____ babbled
_____ put 2 words together
_____ sat alone
_____ walked
_____ toilet trained (night time)
_____ grasped crayon/pencil
_____ said first word
_____ spoke in short sentences
_____ crawled
_____ toilet trained (day time)

Does your child…

___ choke on food or liquids?
___ put toys/objects in his/her mouth?
___ brush his/her teeth, or allowed brushing?

Current Speech-Language-Hearing

Does your child…

___ repeat sounds, words, phrases over and over?
___ understand what you are saying?
___ point to common objects/pictures on request?
___ follow simple directions? ("Get your shoes.")

___ respond correctly to yes/no questions?
___ respond correctly to wh-questions?

How does your child currently communicate basic needs or desires?

___ pulling others toward desired objects
___ pointing
___ vocalizing (grunts, vowels, whines)
___ single words
___ 2-4 word sentences
___ sentences longer than 4 words
___ other _____

Behavioral Characteristics:

___ cooperative
___ attentive
___ willing to try new activities
___ separation difficulties
___ easily frustrated
___ stubborn
___ leader
___ restless
___ poor eye contact
___ easily distracted
___ shy and withdrawn
___ impulsive
___ self-abusive behavior
___ inappropriate behavior

School History

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

School name and grade that your child is in: _____

Has your child repeated any grades? If so which? _____

Is your child having difficulty with any subjects? _____

What are your child's best subjects? _____

Additional Comments

What outcome would you like from this evaluation/therapy with your child? _____

_____

_____

What questions would you like answered today? _____

_____

_____