CHILD SPEECH-LANGUAGE CASE HISTORY

All information provided on this form will be held in the strictest confidence in accordance with HIPAA regulations.

I. General Information

Today's date: ___________________________

Child's name: __________________________________ Date of Birth: _______________Gender:____________

Address: ____

Preferred phone # to call: _____________________________ Alternate __________________________________

Person completing this form: ________________ Relationship to child: ________________________________

Language(s) spoken in the home: ____

II. Reason For Referral

Are you interested in (1) an evaluation___ (2) treatment ____ (3) evaluation & treatment______

What are your concerns regarding your child's speech or language?

____

____

____

____

What question(s) would you like answered as a result of an evaluation here?

____

____

____

____

Does your child's communication difficulty arise from an injury or illness? ____ yes ____ no If yes, please describe:____

____

____

III. Background Information

Mother: ____ Age: _________________________

Education: _______________________ _______________ Occupation: __________________

Father: ____ Age: _________________________

Education: _______________________________________ Occupation: __________________

Siblings:

Name	Age	Gender	Grade	Any Speech, Hearing, Medical Problems
1.				
2.				
3.				

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Have you or anyone else in your family not listed above experienced speech/language, hearing, learning, or attention problems? If so, please describe: ____
____
____

IV. Birth History

During this pregnancy or delivery, did mother experience any unusual illness or condition such as German measles, Rh incompatibility, special medical care, false labor, etc?____________ If so, please describe:
____
____
Length of Pregnancy: __________ Birth Weight: _____________APGAR Scores (if known): _____
Birth was: Normal ______ Caesarean ______ Breech______ Multiple Birth ______
Was your child in the Neonatal Intensive Care Unit (NICU)? _____________________________
If so, for how long? ____
Please check any conditions that applied to your child *immediately following birth*:
___ Breathing problems ___ Sucking problems ___ Seizures
___ Blue skin ___ Swallowing problems ___ Bruises
___ Jaundice ___ Feeding problems ___ Cord wrapped around neck
___Genetic Disorder ___ AIDS (HIV) ___ Birthmark
Please describe any unusual events or problems during the first year. ________________________
____
____
____

V. Developmental History

At what age did the following occur?
Held up his/her head ________________ Sat alone without support ____________
Pulled up to stand _______________ Walked unaided _________ Was toilet trained ________
Check if your child:
___ Falls or loses balance easily ___ Has difficulty eating ___ Has difficulty swallowing
Compared to other children your child's age, describe how he or she is able to sit, stand, run, and use his or her hands: ____
____
____

VI. Health History

Check any of the following diagnoses that apply to your child:
___ Cleft Lip and/or Palate ___ Attention Deficit Disorder ___ Auditory Processing Disorder
___ Pierre Robin Sequence ___ Tourette's Syndrome ___ Seizure Disorder
___ Down Syndrome ___ Language Learning Disability ___ Hearing Loss
___ Developmental Delays ___ Pervasive Developmental Disorder ___ Autism
___ Asperger Syndrome ___ Other: ____________________
Check any illnesses that your child has had. Please add any others not listed.
___ Measles ___ Encephalitis ___ Chicken Pox ___Hand, Foot, and Mouth disease
___ German Measles ___High Fevers ___ Mumps ___ Pertussis (Whooping cough)
___ Laryngitis ___ Asthma ___ Allergies(hay fever, food) ___ Frequent cases of flu
___ Meningitis ___ Diabetes ___ Cancer ___ Other: _______________
___ Ear Infection(s) *Were tubes inserted? ____ If so, are they currently in the ear? _____

Describe your child's current health status/problems____
____
Current weight ________ Current height ________
Is your child currently being followed by a physician for an injury, illness or condition described above?
_______ If so, please state the reason: ____
____
____
List any medication(s) your child is currently taking and for what conditions: _____________________
____ ____
Did your child ever require hospitalization? ____
If yes, indicate illness or injury, child's age at admission, and the length of stay: __________________
____
____
Does your child currently wear hearing aids? _________

VI. Speech-Language History

At what age did your child: say his/her first words? ______________ use word combinations like "Want cookie" or "Me out?" ____________ use more complete sentences like "Mommy go shopping" or "I fall down?" _______________ Did your child ever start talking, then stop? ________ If so, please describe:
____
How does your child currently communicate? For example, gestures, single words, phrases, complete sentences? ____
How does your child's voice sound? Normal ____Too high pitched _____ Too low pitched ____
Hoarse _____ Nasal _____
Does your child stutter on sounds or words? ____
Does your child have difficulty making any particular speech sounds? _____ If so, which ones?
____
Do others, outside your family, have trouble understanding your child? _______________________
Does your child seem to be aware of speaking differently from others? _____ If so, describe: ________
____
Does your child seem to have any difficulty understanding speech or directions? Please describe:
____
____
Is your child frustrated by his or her communication difficulties? ______________________________
____

VII. Pre-school History (*Complete only if your child currently attends preschool.*)

Name of program: ____
How often does your child attend? ____
Has the teacher ever expressed concern about your child's speech or language? ________________
If so, what were the concerns? ____
How does your child get along with others at pre-school? ___________________________________
____

VIII. School History

Is your child homeschooled? _______ Alone or with siblings? ______________ Grade: ______
School child attends: ____

What are your child's average grades: ____________Strong subjects: ___________________________
Weak subjects: ____
Have any of your child's teachers expressed concerns about his or her speech, language, or academic skills? If so, what were they?____
____
____

How does your child get along with others at school? ____
____

Are you concerned about any behavioral issues? _____If so, describe:___________________
____

Does your child have a current IEP (Individualized Educational Program)? ______In what area (s) of exceptionality does he or she qualify for services? ____

Is your child receiving services at school _________If yes, please list professionals working with him or her:____
____

IX. Evaluations and Treatment

Has your child had a prior speech-language evaluation? ______When, where, and with whom?______
____
Results: ____
____
Does your child currently receive speech-language therapy? ______With whom? _________________
Did you child ever receive speech-language therapy? ________What was the nature of the therapy? _________________________________When did it end?____
Has your child had a hearing test or auditory processing evaluation? ___________
When and where? ____
What were the results? ____
Has your child had a neurological evaluation? __________________________
When and where? ____
What were the results? ____
Has your child had a psycho-educational evaluation? ____________________
When and where? ____
What were the results? ____

X. Additional Information

Please write any additional information you think will help us in addressing your concerns.