Speech Therapy
Child Case History Form

Child's Name:		**D.O.B.**
Address:		**Phone:**
City:	**State:**	**Zip:**

Does the child live with both parents? _____

Mother's Name:	**Age:**
Occupation:	**Work Phone:**

Father's Name:	**Age:**
Occupation:	**Work Phone:**

Pediatrician:	**Phone:**
Family Doctor:	**Phone:**
Referred By:	**Phone:**

Sibling #1	**Age:**
Sibling #2	**Age:**
Sibling #3	**Age:**
Sibling #4	**Age:**
Sibling #5	**Age:**

What language does the child speak? _____

What is the child's primary language?_____

What languages are spoken at home?_____

With whom does the child spend most of his or her time? _____

Please describe why you are having your child seen for a speech-language evaluation (e.g. voice, stuttering, expressive/receptive language delay, articulation, reading difficulty, etc)

_____
_____
_____

How does the child usually communicate (gestures, single words, short phrases, sentences)?

_____
_____
_____

Please give two to three examples of your child's comments that are typical at this time

_____
_____
_____

When was the problem first noticed? _____
_____

By Whom? _____

What do you think may have caused the problem?

_____
_____
_____
_____

Has the problem changed since it was first noticed? _____
(If yes, explain)

_____
_____
_____
_____
_____

Is the child aware of the problem? _____
If yes, how does he/she feel about it?

_____
_____
_____
_____
_____

Have any other speech-language specialists seen the child? _____
Who? _____
When? _____
What were their conclusions or suggestions?

_____
_____

Have any other specialists (physicians, psychologists, special education teachers, etc.) seen the child? _____
If yes, What type of specialists? _____
When was the child seen? _____
What were the specialist's conclusions or suggestions?
_____
_____
_____
_____
_____

Are there any incidences of any of the following conditions among the child's family/close relatives (maternal and paternal)?

	Yes	No	Please explain
1. Speech problems			
2. Hearing problems			
3. Learning disabilities			
4.Seizures/convulsions			
5. Mental retardation			
6. Autism/spectrum disorder			

Parental and Birth History

Mother's general health during pregnancy (illnesses, accidents, medications, etc.)
_____
_____
_____

Length of Pregnancy: _____ Length of Labor: _____
Birth Weight: _____ General condition: _____

Circle type of delivery: head first feet first breech Caesarian

Were there any unusual conditions that may have affected the pregnancy or birth?
_____
_____
_____

Did child experience any early feeding/swallowing problems (weak suck, turning "blue" while attempting to nurse, projectile vomiting, choking, lack of appetite, early fatigue, milk coming out nose while nursing, etc.)?

_____

_____

_____

Medical History

Does your child have a history with:

	Yes	No	At what age?
Ear infections			
PE tubes			
Frequent colds/sinus infections			
Bronchitis/pneumonia			
Drainage from ear			
Tonsils/adenoids removed?			

Has child experienced any of the following? Please explain all "yes" responses below:

	Yes	No
Visual difficulities		
High fevers lasting longer than 1 day		
Seizures/Convulsions		
Tuberculosis		
Asthma		
Hospitalization		
Surgery		
Encephalitis		
Head injury		
Swallowing/chewing problems		
Other		

Please explain all “yes” answers:

_____

_____

_____

_____

Describe any major accidents or hospitalization:

_____

_____

Does child have any medical diagnoses? (e.g., ADD, autism, dyslexia)?

_____

_____

Is the child taking any medications? _____ If yes, identify:

_____

_____

_____

_____

_____

Have there been any negative reactions to medications? _____ If yes, identify:

_____

_____

_____

_____

_____

Does your child have any known allergies?_____If yes, identify:

_____

_____

_____

Developmental History

Did your child:

	Yes	No	If no, at what age:
Hold his/her head up by 4 months?			
First crawl by 12 months?			
First walk alone by 16 months			
Was toilet-trained by 3 years			
First grasped crayon/pencil (thumb and finger) by 3 years?			
First sit alone by 12 months?			
First ate solid food by 12 months?			
Fed self by 2 years?			
First use scissors by 3 years?			
Did child cry normally (to communicate pain, fear, discomfort, loneliness)?			
Cooing/ babbling by age 4 months?			
Respond to name/peek-a-boo by 8 months?			
Using jargon* by 12 months?			
Imitate sounds by 12 months?			

Saying his first word by 15 months?			
saying 2 words together by 24 months?			
using short sentences by 36 months?			

- *Jargon is defined as words that are not understandable, but are said in "sentences," where the child's inflections let you know that he is "saying something."*

Please describe your child's gross motor skills (coordinated, clumsy, falls a lot, slow, etc.) while walking, running, climbing, riding bikes, roller skating, etc.

_____
_____
_____
_____

Please describe your child's fine motor skills while attempting to color, write, draw, cut with scissors, feed him/herself with utensils, etc.

_____
_____
_____
_____

Describe the child's response to sound (e.g., responds to all sounds, responds to loud sounds only, inconsistently responds to sounds, etc.)

_____
_____
_____
_____
_____

Has your child's hearing been tested previously?_____If yes, when and what were the results?

_____
_____
_____

Indicate with a checkmark any items that are difficult for your child:

- ☐ Eating a variety of foods
- ☐ Understanding what he/she hears
- ☐ Following directions or routines
- ☐ Speaking in organized or grammatically correct sentences
- ☐ Answering questions
- ☐ Pronouncing words correctly
- ☐ Singing songs / reciting nursery rhymes
- ☐ Stating sounds of letters

- [ ] Recognizing "common" words
- [ ] Rhyming
- [ ] Thinking of words for things
- [ ] Telling stories
- [ ] Receiving/giving hugs
- [ ] Eye-Hand Coordination
- [ ] Blowing bubbles
- [ ] Writing his/her name
- [ ] Getting his/her point across
- [ ] Understanding concept of time (seasons, day/night, hours)
- [ ] Self-calming
- [ ] Keeping shoes on
- [ ] Using a straw
- [ ] Keeping hands to him/herself

Behavioral History

Please check all that describe your child:

- [ ] Friendly
- [ ] Easy-going
- [ ] Plays well with other children
- [ ] Aggressive/destructive
- [ ] Has temper tantrums
- [ ] Unpredictable
- [ ] Sleeps well
- [ ] Eats well
- [ ] Plays alone for reasonable amount of time
- [ ] Doesn't like to be touched
- [ ] Talkative
- [ ] Clumsy
- [ ] Impulsive/impatient
- [ ] Difficulty sleeping
- [ ] Hyperactive
- [ ] Doesn't like to be read to
- [ ] Poor memory
- [ ] Defiant
- [ ] Cannot easily shift from one activity to another
- [ ] Bites nails
- [ ] Stubborn
- [ ] Bad-tempered
- [ ] Cries easily
- [ ] Separation difficulties
- [ ] Poor eye contact
- [ ] Cooperative
- [ ] Attentive
- [ ] Willing to try new activities
- [ ] Will not eat certain textures
- [ ] Will not touch certain textures
- [ ] Overly sensitive emotionally
- [ ] Still uses pacifier/sucks thumb
- [ ] Has nightmares
- [ ] Grinds teeth

- ☐ Distractible/short attention span
- ☐ Wets bed
- ☐ Easily frustrated
- ☐ Withdrawn
- ☐ Mouth breather
- ☐ Restless
- ☐ Shy
- ☐ Snores
- ☐ Quiet
- ☐ Daydream often
- ☐ Sensitive to sounds

Educational History

School _____
Grade _____ Teacher(s) _____

How is the child doing academically (or pre-academically)?

_____
_____
_____
_____
_____

Does the child receive special services? _____ If yes, describe

_____
_____
_____
_____
_____

How does the child interact with others: (e.g., shy, aggressive, uncooperative, etc.)

_____
_____
_____
_____
_____

If enrolled for special education services, has an Individualized Educational Plan (IEP) been developed? _____ If yes, describe the most important goals:

_____
_____
_____
_____
_____

Provide any additional information that might be helpful in the evaluation or remediation of the child's problem:

_____
_____
_____
_____

Person completing form: _____ Date _____
Signature: _____
Relationship to child: _____