Speech-Language Case History Form

Identifying and Family Information

Child's Name: _____ **Date of Birth:** _____ **Age:** _____

Diagnosis (if any): _____ **Age of Diagnosis:** _____

Mother's Name: _____ **Occupation:** _____
Daytime Phone: _____ **Cell Phone:** _____
Address: _____
E-mail Address: _____

Father's Name: _____ **Occupation:** _____
Daytime Phone: _____ **Cell Phone:** _____
Address (if different from above): _____
E-mail Address: _____

Doctor's Name: _____ **Clinic Name:** _____
Doctor's Phone: _____ **Doctor's Fax:** _____

Child lives with:
( ) Birth parent(s) ( ) Adoptive parent(s) ( ) Other _____

Parents are: ( ) Married ( ) Separated ( ) Divorced ( ) Other: _____

If your child was adopted, at what age and from where? _____

Please list other children in the family:

Name	Age	Speech/Hearing Problems?

Is there another language other than English spoken in the home? ( ) Yes ( ) No
If yes, what language? _____

What are your child's interests/motivators?_____
_____
_____
_____

Birth History

Was there anything unusual about the pregnancy or birth? ( ) Yes ( ) No
If yes, please describe: _____

Was the mother ill during the pregnancy? ( ) Yes ( ) No
If yes, please describe: _____

Did the mother take any medications during the pregnancy? ( ) Yes ( ) No
If yes, please list: _____

Was the pregnancy full-term? ( ) Yes ( ) No
If no, how many weeks was the pregnancy? _____

Was labor normal? ( ) Yes ( ) No
If no, please explain: _____

Delivery was: ( ) vaginal ( ) planned cesarean ( ) emergency cesarean ( ) breech

Was your child hospitalized after birth? ( ) Yes ( ) No
If yes, for what and how long? _____

Birth Weight: _____ **Length**: _____ and **APGAR scores:** _____

Is there any other information about the mother or baby that may be pertinent?

_____
_____
_____

Medical History

Has your child had any of the following? Check all that apply:

( ) Adenoidectomy
( ) Breathing Difficulties/Asthma
( ) Chicken Pox
( ) Ear Infections – How often/many?
_____
( ) Ear Tubes – When?
_____
( ) Head Injury
( ) High Fevers
( ) Meningitis
( ) Seizures
( ) Sleeping Difficulties
( ) Tonsillectomy
( ) Vision Problems

Have you ever questioned your child's ability to hear normally? ( ) Yes ( ) No
If yes, please explain: _____

Has your child ever had his or her hearing tested? ( ) Yes ( ) No
If yes, what were the results? _____

Have you ever questioned your child's ability to see normally? ( ) Yes ( ) No
If yes, please explain: _____

Has your child's vision been tested? ( ) Yes ( ) No
If yes, what were the results? _____

Has your child been seen by any medical specialists? ( ) Yes ( ) No
If yes, please explain? _____

Other serious injuries/surgeries: _____

Has your child been diagnosed with any of the following? Check all that apply:

( ) Attention Deficit Disorder (ADD)
( ) Autism (ASD)
( ) Asperger's Syndrome
( ) Epilepsy/Seizure Disorder
( ) Pervasive Developmental Disorder (PDD)
( ) Reflux
( ) Sensory Integration Disorder (SID)
( ) Other _____

Please list current medications and their purpose:_____
_____

Are there any precautions that should be taken with your child?
(i.e. food allergies, aggressive behavior, decreased awareness of safety, etc.)
_____
_____

Please describe any pertinent family medical history (i.e. mother, father, siblings, and grandparents):
_____
_____

Developmental History

Do you have any concerns about your child's overall development? ( ) Yes ( ) No
If yes, what are they? _____
_____

Have you shared your concerns with your child's doctor? ( ) Yes ( ) No
If yes, what were the recommendations, if any? _____
_____

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

Babbled _____
Used single words _____
Began combining words _____
Spoke in short sentences _____
Ate table foods _____
Fed self _____
Toilet trained _____
Rolled over _____
Crawled _____
Sat alone _____
Stood alone _____
Walked independently _____
Grasped a crayon _____
Dressed self _____

Does your child choke or cough when eating or drinking? ( ) Yes ( ) No
Does your child have difficulty chewing certain textures? ( ) Yes ( ) No
Does your child currently put toys/objects in his/her mouth? ( ) Yes ( ) No
Does your child brush his/her teeth and/or allow brushing? ( ) Yes ( ) No
Is your child a picky eater? ( ) Yes ( ) No
If yes, please describe any aversions to textures, temperatures, etc.: _____
_____

Is your child currently on a GFCF diet? ( ) Yes ( ) No
Are there any other food restrictions? ( ) Yes ( ) No
If yes, please list: _____

What are behavioral characteristics your child demonstrates? **Check all that apply:**

( ) cooperative/attentive
( ) willing to try new activities
( ) usually happy/easygoing
( ) plays/shares well with others
( ) shy/quiet
( ) easily frustrated
( ) impulsive/distractible
( ) stubborn/resistant to change
( ) avoids touch
( ) craves touch
( ) poor eye contact
( ) repetitive behaviors
( ) short attention span/restless
( ) tires easily
( ) destructive/aggressive
( ) withdrawn
( ) self-abusive behavior
( ) other: _____

Has your child ever gained skills and then lost them in any developmental area? ( ) Yes ( ) No
If yes, please explain:
_____
_____
_____

Speech-Language History

Do you feel that your child has a speech/language problem? ( ) Yes ( ) No
If yes, please describe: _____
If yes, who first noticed the problem and when? _____

Has your child ever had a speech evaluation/screening? ( ) Yes ( ) No
If yes, when, where, and what were you told? _____
_____
_____

Has your child ever had speech-language therapy? ( ) Yes ( ) No
If yes, when and where? _____

Has your child ever received any other evaluations or therapy? ( ) Yes ( ) No
If yes, please describe: _____

Is your child aware of, or frustrated by, any speech/language difficulties? ( ) Yes ( ) No
If yes, please describe: _____

What do you see as your child's most difficult problem(s)? _____
_____

My child…
( ) repeats sounds, words, or phrases over and over
( ) understands words
( ) understands sentences
( ) understands conversation
( ) retrieves/points to common objects upon request
( ) follows 1- step directions
( ) follows 2-step directions
( ) responds correctly to yes/no questions
( ) responds correctly to 'wh' questions
( ) asks questions of others

My child currently communicates using…
( ) crying or tantrums
( ) body language (i.e. pointing, looking, gesturing)
( ) sounds (i.e. vowel sounds, grunting)
( ) single words
( ) 2 to 4 word sentences
( ) sentences longer than 4 words (provide example): _____
( ) other _____

** **Check all that apply****

If your child typically is using words or sentences, please indicate if s/he is difficult to understand:
By you: ( ) Yes ( ) No By others: ( ) Yes ( ) No
If yes, How? **Check all that apply:**

Speech Sounds:
( ) omits sounds
( ) distorts sounds
( ) substitutes sounds
( ) other: _____

Language:
( ) word order
( ) omits words
( ) speaks in only words/phrases
( ) other: _____

Fluency/Voice:
( ) word or sound repetitions
( ) frequent and/or long pauses
( ) frequent use of "um" or "uh"
( ) unusual vocal quality or volume

Estimate the percentage of time your child's speech is understood:
By you: _____% By others: _____%

Social Interaction

Does your child interact with other children? ( ) Yes ( ) No
Describe how your child interacts with other children:

_____
_____
_____

Does your child interact with adults? ( ) Yes ( ) No
Describe how your child interacts with adults:

_____
_____
_____

Play Skills

Does your child prefer to play alone? ( ) Yes ( ) No
What games and toys does your child prefer?

_____
_____
_____

Describe how your child plays with toys:

_____
_____
_____

Does your child play with other children? ( ) Yes ( ) No
If yes, describe how your child plays with other children:

_____
_____
_____

Education History

Name of school and grade: _____

What are your child's strengths and/or best subjects? _____

Which subjects are more challenging for your child?_____

Is your child receiving specialized/additional services through the school? ( ) Yes ( ) No
If yes, please explain: _____

Does your child's performance become better or worse in different settings/situations? ( ) Yes ( ) No
If yes, please describe: _____

If your child has an IFSP/IEP in place and/or other evaluation reports please include a copy. Also, if you would like there to be communication between Holland Center and the school support staff/therapists/teachers, please complete a Release of Information form.

Thank you for taking the time to complete this form. Please address any additional concerns below.

Additional Comments/Concerns

Name of person completing this form: _____

Relationship to the child: _____ Date form was completed: _____