Children's
Speech & Language Services

CASE HISTORY FORM
SPEECH, LANGUAGE AND HEARING DEVELOPMENT

Date _____

Child's Name _____
Last **First** **Middle** **Nickname**

Birthdate _____
Parent's Names _____
Parent's Address _____
_____ **Zip** _____

Home Phone Number _____ **Work** _____

Cell phone _____ **E-mail** _____
Insurance Company _____ **Policy No.** _____
Primary Insurance Holder Date of Birth _____
Mother's Employer: _____
Father's Employer: _____
Your relationship to patient _____
Person who recommended our services to you _____
Name of Pediatrician _____
Primary reason for bringing your child for this evaluation: _____
_____

		Yes	No
I	**Birth and Developmental History**		
	A. Pregnancy		
	1. Was mother's condition during pregnancy good to excellent?	___	___
	2. Were medications taken during pregnancy?	___	___
	3. Were there any illnesses or complications during pregnancy? If yes, please give brief description. _____	___	___
	4. Was baby born at term (due date) or within two weeks before or after due date?	___	___
	5. What was birth weight? _____		
	6. Was the child adopted?	___	___
	7. Child has no known allergies?	___	___

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Allergies

⍟8. Food, medication or environmental allergies

_____

_____

⍟ 9. Does your child require/carry an EpiPen for any allergies?

_____

If your child carries an EpiPen daily due to severe allergies, parent and/or caregiver must remain in our waiting room during all therapy sessions. Initial _____

	Yes	No
B. Labor and Delivery		
1. Were labor and delivery normal?	___	___
2. Was labor induced?	___	___
3. Was there evidence of injury or poor health at birth?	___	___
4. During the first month of life, was child's health good to excellent?	___	___
C. Infancy and Early Childhood		
1. Were there any feeding problems?	___	___
2. Was the baby of average activity level?	___	___

II. Medical History

1. Circle diseases child has had; note ages, severity, whether accompanied by high fever, and the effects:

Disease	Age	Severity & Effects	High Fever?
Mumps			
Measles			
Chicken Pox			
Chronic Colds			
Tonsillitis			
Middle Ear Infections			
Seizures			
Allergies			
(Food, environmental, asthma)			
Other			

If your child has a seizure disorder and/ or carries an EpiPen daily due to severe allergies, parent and/or caregiver must remain in our waiting room during all therapy sessions. Initial _____

List Injuries	Age	Severity	Hospitalized?

Yes No

2. **Is medication taken regularly for any reason?** ___ ___
   If so, what? _____
   Was development of teeth normal? ___ ___

3. **Please elaborate on the frequency of middle ear infections and their severity. Were antibiotics effective in treating the problem?**

_____

_____

III Social and Emotional Development

1. **If your child exhibits or has exhibited the following behaviors, please Indicate age at occurrence and whether you have attempted to deal with it:**

Behavior	**Age (from) Age (to)**	**Attempted to Alter these? (yes/no)**
Shyness		
Thumb Sucking		
Difficulty Separating from Parents		
Face Twitching		

Behavior	**Age (from) Age (to)**	**Attempted to Alter these? (yes/no)**
Strong Fears/Nightmares		
Temper Tantrums		
Sleeplessness		
Nervousness		
Difficulty Sitting Still		
Inability to Stay with One Activity Until Completion		
Negative Behaviors		
Bedwetting		

Yes No

2. **Does the child have the opportunity to play with other children his age?** ___ ___

3. **If so, does he play with them?** ___ ___

4. **Does he play with younger children?** ___ ___

5. **Does he play with older children?** ___ ___

6. Are you ever concerned because he doesn't play well with other children? ___ ___

7. What type of activity does your child prefer? _____
_____

8. Primary type of discipline: spanking ___; isolation ___ (sending to room); verbal reasoning ___; other _____
_____

9. Do you feel that your approach to discipline is effective? ___ ___
Yes No

IV. Motor Development

1. Please indicate age when the following skills were first preformed:

Skill	Age	Skill	Age
Creeping		Holding Cup	
Crawling		Using Spoon	
Sitting Unassisted		Using Fork	
Walking		Using Crayons	
Hopping		Using Scissors	
Skipping			

	Yes	No	?
2. Has the child established handedness? If so, which hand? _____	___	___	___
3. Indicate age when voluntary bladder control was achieved? _____ Bowel control? _____			
4. Was there any difficulty in toilet training?	___	___	___

V. Speech and Language Development and Behavior

1. At what age did he/she babble? _____
Imitate words? _____
Use his first word meaningfully? _____
Put words together? _____

2. Did speech and language skills seem to develop normally and then stop or regress?	___	___	___
3. Does he understand what is said to him?	___	___	___
4. Does he follow spoken directions?	___	___	___

5. Does he talk in (check all that apply):
single words ___; phrases ___; complete but grammatically incorrect sentences ___;
complete, grammatically correct sentences ___;

other _____.

		Yes	No	?
6.	**Does he retell stories or experiences that can be understood?**	___	___	___
7.	**Does he often hesitate and/or repeat sounds and words?**	___	___	___

8. **Is his speech: too fast ___; too slow___; average ___?**
9. **Is his voice: too soft ___; too loud ___; average loudness ___; hoarse ___; nasal ___; denasal (stuffed as during a cold____; other ___.**

10. **Has he ever had speech or language therapy:** ___ Yes ___ No

By whom? _____
Where?
_____
Dates? _____

VI. Auditory / Sensory Behaviors

1.	**Does your child seem to have a hearing difficulty?**	___ Yes	___ No
2.	**Is he inconsistent in his response to sounds and voices?**	___ Yes	___ No
3.	**Is your child overly sensitive to noise? touch?**	___ Yes	___ No

VII. Environmental History

Names of Siblings **Birth Dates**

_____
_____
_____

Others in the Home _____
_____

Primary language used at home by mother:_____ father:_____

Briefly describe daily environment. Does your child attend day care or have a primary care provider who has English as a second language? If so, what language is spoken?

_____
_____

Have any other family member or relatives had the following difficulties?

Difficulty	Yes	No	Relationship to Child
Speech or Language Problem			
Hearing Problem			
Learning Disability			
Reading Problem			
Emotional Problems			
Mental Problems			

VIII. School History

1. **Schools Attended** **Grade Level** **Dates**

   _____

   _____

2. **Does his schoolwork seem inadequate in any areas?** ___ Yes ___ No

   If so, in what areas? _____

3. **Please indicate present school hours**
   Days of the week in attendance

IX. Other Evaluations

Has your child been seen by any other specialists? ___ Yes ___ No

Who? **Where? (Please list)**

_____

_____

_____

_____

_____ _____

Parent/ Guardian Signature **Date**