

CHILD CASE HISTORY FORM

General Information

Child's Name: _____ Date of Birth: _____

Address: _____ Phone: _____

City: _____ Zip: _____

Does the child live with both parents? _____

Mother's Name: _____ Phone: _____

Mother's Occupation: _____

Father's Name: _____ Phone: _____

Father's Occupation: _____

Referred By: _____

Doctor: _____ Phone: _____

Address: _____

Brothers and Sisters (include names and ages):

What is the child's primary language? What languages does the child speak?

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

Describe the child's speech-language problem:

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

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?

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

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

Have any other specialists (physicians, psychologists, special education teachers, etc.) seen the child? If yes, indicate the type of specialist, when the child was seen, and the specialist's conclusions or suggestions:

Are there any other speech, language, or hearing problems in your family? If yes, please describe:

Personal and Birth History

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

Length of pregnancy: _____

General condition: _____ Birth weight: _____

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

Medical History

Has the child suffered from any of the following illnesses or conditions? At what age did it start or occur?

Allergies _____	Asthma _____	Chicken Pox _____
Colds _____	Convulsions _____	Croup _____
Dizziness _____	Draining Ear _____	Ear Infections _____
Encephalitis _____	German Measles _____	Headaches _____
High Fever _____	Influenza _____	Mastoiditis _____
Measles _____	Meningitis _____	Mumps _____
Pneumonia _____	Seizures _____	Sinusitis _____
Tinnitus _____	Tonsillitis _____	Other _____

Has the child had any surgeries, major accidents, or hospitalizations? If yes, describe:

Is the child taking any medications, and have there been any negative reactions to medications? If yes, identify and describe:

Developmental History

Provide the approximate age at which the child began to do the following activities:

Crawl _____ Sit _____ Stand _____
Walk _____ Feed self _____ Dress self _____
Use toilet _____

Use single words (e.g., *no, mom, doggie*, etc.): _____

Combine words (e.g., *me go, daddy shoe*, etc.): _____

Name simple objects (e.g., *dog, car, tree*, etc.): _____

Use simple questions (e.g., *Where's doggie?*, etc.): _____

Engage in a conversation: _____

Does the child have difficulty walking, running, or participating in other activities which require small or large muscle coordination? Yes No

Are there or have there ever been any feeding problems (e.g., problems with sucking, swallowing, drooling, chewing, etc.)? If yes, describe: Yes No

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

Educational History

School: _____ Grade: _____

Teacher(s): _____

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

Does the child receive special services? If yes, describe: ___ Yes ___ No

If enrolled for special education services, has an Individualized Educational Plan (IEP) been developed?
If yes, describe the most important goals: ___ Yes ___ No

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

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

Person completing form: _____

Relationship to child: _____

Sign: _____ Date: _____