

Child Case History Form

General Information

Date: _____

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

Address: _____ Phone: _____

_____ Cell Phone: _____

City: _____ Zip: _____ E-mail: _____

Does the child live with both parents? _____

Mother's Name: _____ Age: _____

Mother's Occupation: _____ Business Phone: _____

Father's Name: _____ Age: _____

Father's Occupation: _____ Business Phone: _____

Referred By: _____ Phone: _____

Address: _____

Brothers and Sisters (include names and ages):

Describe the child's speech-language problem.

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

What languages are spoken in the home? What is the primary language spoken?

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

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 changes 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, psychologist, 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.

Prenatal and Birth History

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

Length of pregnancy:

Length of Labor:

General condition:

Birth weight:

Circle type of delivery: head first feet first breech Caesarian

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

Medical History

Provide the approximate ages at which the child suffered the following illnesses and conditions:

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

Has the child had any surgeries? If yes, what type and when (e.g., tonsillectomy, adenoidectomy, etc.)?

Describe any major accidents or hospitalizations.

Is the child taking any medications? If yes, identify.

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

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 the doggie?, etc.):

Engage in conversation:

Does the child have difficulty walking, running, or participating in other activities which require small or large muscle coordination?

Are there or have there been any feeding problems (e.g., problems with sucking, swallowing, drooling, chewing, etc.)? If yes, describe.

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 preacademically)?

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 Education 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.

Copies of this report should go to:

Person completing this form:

Relationship to child:

Signature: _____