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Speech-Language-Hearing Case History Form

Child's Name: ______________________________ Date of Birth: ________________________

Parent's Name(s): ____________________________ Home Phone: _______________________

Cell Phone: ________________________________ Work Phone: __________________________

Home Address: ____

Email: ____

Parent's Occupation: ____

Child's School: ____ Grade: ____________

Referred By: ____

Doctor's Name: __________________________ Doctor's Phone: _________________

Child lives with (check one):
•Birth Parents •Foster Parents
•Adoptive Parents •One Parent
•Parent & Step-parent •Other: ____

FAMILY HISTORY
Siblings and ages:
____

Is there a family history of speech, language or learning issues? (If yes, please check)

- Speech/Language Difficulties (including dyslexia)
- Hearing Impairment/Deafness
- Learning Difficulties
- Developmental Difficulties

What are your current concerns?

____

____

____

OTHER LANGUAGE EXPOSURE

Is there a language other than English spoken in the home? ☐ Yes ☐ No
If yes, which language? ________________________________
Does the child speak this language? ☐ Yes ☐ No
Does the child understand this language? ☐ Yes ☐ No
Which language does the child prefer to speak at home? ________________
At school? ___________________

BIRTH AND MEDICAL HISTORY

Was there anything unusual about the pregnancy or birth? ☐ Yes ☐ No
If yes, please explain:

____

____

How many weeks gestation? _________ Birth weight________ Length __________
Was the mother sick during pregnancy? ☐ Yes ☐ No
Was delivery ☐ vaginal ☐ C-section
Apgar Score __________
Discharged within customary time frame ☐ Yes ☐ No

Has your child had any of the following (please check)

- ☐ Adenoidectomy
- ☐ Allergies
- ☐ Breathing Difficulties
- ☐ Feeding Issues
- ☐ Frequent Colds
- ☐ **Frequent Ear Infections**
- ☐ Ear (PE) Tubes
- ☐ Reflux
- ☐ Seizures
- ☐ High Fevers
- ☐ Head injury
- ☐ Sleeping Difficulty
- ☐ Thumb/Finger Sucking
- ☐ Tonsillectomy
- ☐ Tonsillitis
- ☐ Vision Problems
- ☐ Tongue Tie Revision
- ☐ OTHER

If you checked any, please provide details/dates:

____
____
____

Other serious illness/injury? ☐ Yes ☐ No
Please list: ____

Date of last hearing screening: ____________ Results: _________________________

Date of last vision screening: ______________Results: _________________________

Hospitalizations (dates and procedure):
____

Medications (what medications and for what purpose please list)
____
____

Please indicate approximate age your child reached the following milestones:

sat unsupported __________ grasped crayon/pencil _________________

babbled ____________ crawled _____________________

uttered first word(s) __________ put two words together_____________

spoke in short sentences __________ walked __________________

completed toilet training ___________________

ORAL MOTOR FUNCTION

Has your child experienced feeding/eating difficulties (e.g., biting, swallowing, chewing, restricted range of foods)? ☐ Yes ☐ No

If yes, please explain:
____
____
____

Was your child breast-fed or bottle-fed? How was his/her experience?

____

Does your child eat by self using utensils? ☐ Yes ☐ No

Does your child drool? ☐ Yes ☐ No

Does your child put toys in mouth? ☐ Yes ☐ No

Does your child have food allergies? ☐ Yes ☐ No
If yes, please explain:
____

Does your child have food **preferences/aversions**? ☐ Yes ☐ No
If yes, please explain:
____
____
____

SPEECH AND LANGUAGE DEVELOPMENT

How does your child prefer to communicate? (Please check)
gestures _______ words _______ push/pull _______ pointing_________crying______

Number of words in a typical sentence? ______________________________

Is your child's speech difficult to understand? ☐ Yes ☐ No

Does your child: identify objects? ☐ Yes ☐ No

Does he/she ask questions? ☐ Yes ☐ No

Follow directions? ☐ Yes ☐ No

Understand what you are saying? ☐ Yes ☐ No

Respond correctly to yes/no questions? ☐ Yes ☐ No

Respond correctly to "WH" (who, what etc.) questions? ☐ Yes ☐ No

Does your child have any social difficulties with peers? ☐ Yes ☐ No

Does your child have difficulty paying attention? ☐ Yes ☐ No

Does your child have difficulty labeling colors, shapes, letters? ☐ Yes ☐ No

Does your child have difficulty sounding out words and/or reading ☐ Yes ☐ No

Has your child ever received a speech/language evaluation? ☐ Yes ☐ No

Date(s) ____

Has your child received speech/language therapy previously? ☐ Yes ☐ No

If yes, when? For how long?

____

Is your child aware of, or frustrated by, any speech/language difficulties? ☐ Yes ☐ No

SERVICES (please indicate what types of services your child has received) ST, OT, PT, Special Education etc).

<u>County/District Level</u>

Early Intervention: ____

Preschool: ____

Elementary School:

____

Middle School: ____

Does your child currently have an IEP? ____no ____yes

If yes please state in what area(s)

____

____

Does your child have building level/transitional services without an IEP in any area? (If yes please indicate)

____

____

Does your child have any medical or developmental diagnosis?

____

***Please ATTACH or mail in any evaluations, progress notes and IEP's**

<u>Private Therapy</u> (please indicate what type of therapy, duration and dates)

____

____

SCHOOL HISTORY

Has your child ever repeated a grade? _____ If so, what grade? __________________

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

Is your child having difficulty with a particular subject? __________________________

If yes, what subject? ____

Does your child have tutoring services outside of school? ☐ Yes ☐ No
If yes, please explain: ____

Favorite Activities:
Please list your child's favorite activities, hobbies, toys, interests etc.

____

Please add any additional information that may be helpful

____

____

____

____

____