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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).

County/District Level

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**

Private Therapy (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
