Speech Pathology Solutions, LLC

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: _____ Age: _____

Mother's Occupation: _____ Business Phone: _____

Father's Name: _____ Age: _____

Father's Occupation: _____ Business Phone: _____

Referred By: _____ Phone: _____

Address: _____

Pediatrician: _____ Phone: _____

Address: _____

Family Doctor: _____ Phone: _____

Address: _____

Brothers and Sisters (include names and ages)

_____

_____

_____

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?

_____

_____

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

_____
_____
_____

Describe the child's speech-language problem.

_____
_____
_____

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

_____
_____
_____

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

_____
_____
_____

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 pregnancy or birth?

_____
_____
_____
_____
_____

Medical History

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

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? If yes, what type and when (e.g., tonsillectomy, tube placement, etc.)?

_____
_____
_____

Describe any major accidents or hospitalizations.

_____
_____
_____

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

_____
_____
_____

Has the child's hearing been tested? NO YES

Date of most recent test _____ Results _____
_____

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 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 ever 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.). _____

_____
_____
_____

Education History

School: _____ Grade: _____

Teacher(s): _____

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

_____
_____
_____

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 Educational Plan (IEP) been developed? If yes, describe the most important goals.

_____
_____
_____

What motivates your child? (specific toys, games, music, etc…)

_____
_____

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

_____
_____
_____

Feeding/Swallowing

Describe behaviors during meals. Is mealtime stressful? Why?

_____
_____
_____
_____

Has your child been tested for allergies? What kind? Results?

_____
_____
_____

Is your child exposed (or has been) to second-hand smoke?

_____
_____
_____

Does your child experience or have a history of:

_____eczema _____vomiting

_____rhinitis _____diarrhea

_____asthma _____reflux

_____blood in stool

Describe any family history of allergies.

_____
_____
_____

Feeding/Swallowing

Describe the typical daily diet.

Breakfast

_____
_____
_____
_____
_____
_____

Lunch

_____
_____
_____
_____
_____
_____

Dinner

_____
_____
_____
_____
_____
_____

Person completing form: _____

Relationship to child: _____

Signed: _____ Date: _____