Speech Pathology Solutions, LLC

Child Case History Form

General Information

Child's name: _____ _____ Date of Birth: _____

Address: _____ Phone#/Carrier: _____

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)?

_____
_____
_____
_____

Does the child suck his or her thumb? Or does the child have any other sensory seeking

behaviors?

_____
_____
_____
_____

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:

Seasonal Allergies _____ Food 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 _____ ASD (Autism Spectrum Disorder)_____ SPD (Sensory Processing Disorder)_____ ADD (Attention Deficit Disorder)/ADHD (Attention Deficit Hyperactivity Disorder)_____

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

_____
_____
_____
_____

What motivates your child? (e.g., specific toys, games, music, 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:

_____

Signed: _____ Date:

_____