



# Speech/Language - Child Case History Form

Name \_\_\_\_\_ Date \_\_\_\_\_

Date-of-Birth \_\_\_\_\_ Age \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_

Native Language \_\_\_\_\_ Primary Language \_\_\_\_\_

Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_

Address \_\_\_\_\_ Address (if different) \_\_\_\_\_

Phone \_\_\_\_\_ Phone \_\_\_\_\_

Home      Work      Cell      (CIRCLE ONE)

Home      Work      Cell      (CIRCLE ONE)

Alternate Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_

Home      Work      Cell      (CIRCLE ONE)

Home      Work      Cell      (CIRCLE ONE)

Email Address \_\_\_\_\_ Email Address \_\_\_\_\_

Person Completing Form \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

Referred by \_\_\_\_\_

## COMMUNICATION HISTORY

1. Describe the child's communicative behavior as completely as possible. Include information on use of speech, gesture, facial expression, etc.

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2. What is the reason for your present concern about the child's communication?

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3. What would you hope to gain through the use of our services?

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4. Has the child had any previous evaluation or help with communication?  
Yes \_\_\_\_ No \_\_\_\_ If so, where? \_\_\_\_\_ When? \_\_\_\_\_  
What was the nature of the help? \_\_\_\_\_
5. What things have you tried to change about your child's communicative behavior? Describe.  
\_\_\_\_\_  
\_\_\_\_\_
6. When did you first notice that your child had a communication difficulty? Please explain.  
\_\_\_\_\_  
\_\_\_\_\_
7. What other communication problems have occurred in your family? Explain.  
\_\_\_\_\_  
\_\_\_\_\_
8. At what age did your child begin to talk? \_\_\_\_\_ Imitate sounds? \_\_\_\_\_  
Words? \_\_\_\_\_ Phrases and short sentences? \_\_\_\_\_
9. Can you recall some of his/her words?  
\_\_\_\_\_  
\_\_\_\_\_
10. Was there any early feeding difficulty? \_\_\_\_\_ If so, explain.  
\_\_\_\_\_  
\_\_\_\_\_
11. Has he/she had any difficulty with chewing or swallowing?  
\_\_\_\_\_  
\_\_\_\_\_
12. How does the child react to his/her communication difficulty?  
\_\_\_\_\_  
\_\_\_\_\_
13. How do others react to his/her difficulty?  
\_\_\_\_\_  
\_\_\_\_\_
14. Can you and other family members understand your child's speech? \_\_\_\_\_  
Can unfamiliar listeners? \_\_\_\_\_
15. If your child does not speak, how does he/she communicate wants and needs?  
\_\_\_\_\_  
\_\_\_\_\_
16. Does your child's communication behavior change when he/she talks with different people? (mother, father, brother, sister, teacher, friends, strangers, other children)  
\_\_\_\_\_  
\_\_\_\_\_

17. Does your child's speech sound like other children his/her same age?  Yes  No
18. Is your child able to communicate without getting frustrated?  Yes  No
19. Can your child repeat new words?  Yes  No
20. Do you feel your child can hear well?  Yes  No
21. Has his/her hearing been tested? If yes, when? \_\_\_\_\_  Yes  No
22. Do you feel that your child understands what you say to him/her?  Yes  No
23. Does your child relate well to you?  Yes  No
24. Does your child relate well to others?  Yes  No
25. Does your child understand directions given to him/her?  Yes  No
26. Does your child use a variety of words when he/she communicates?  Yes  No
27. Can your child retell a story or sequences of events?  Yes  No
28. Can your child tell when 2 words rhyme like *mat* and *bat*?  Yes  No

29. What are your child's favorite playthings?

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30. What are your child's favorite activities?

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31. Describe your child's play with his favorite playmates

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32. Who cares for your child when you are not available? (i.e. babysitter, relative, pre-school, day-care)

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Where? At home. \_\_\_\_ Elsewhere. \_\_\_\_

How many times a week is your child in this person's care? \_\_\_\_\_

How does this person react to your child's communication difficulty? \_\_\_\_\_

## BIRTH AND DEVELOPMENTAL HISTORY

1. What, if anything, was unusual about the pregnancy or birth?

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2. How long was the pregnancy? 7 mo. \_\_\_\_ 8 mo. \_\_\_\_ 9 mo. \_\_\_\_ Other \_\_\_\_\_

3. Did the mother take any medications during pregnancy? If yes, please explain

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4. What was birth weight? \_\_\_\_ lb. \_\_\_\_ oz.

5. When did he/she sit unassisted? \_\_\_\_ Walk? \_\_\_\_ Feed himself/herself? \_\_\_\_

6. When was toilet training established? \_\_\_\_\_

## MEDICAL HISTORY

1. What health problems has your child had (nose, throat, ears, etc.)? \_\_\_\_\_

2. Early illnesses and approximate ages:

Measles \_\_\_\_\_ Chicken Pox \_\_\_\_\_ Mumps \_\_\_\_\_

Earaches \_\_\_\_\_ Epilepsy/seizures \_\_\_\_\_ Other \_\_\_\_\_

High Fever \_\_\_\_\_ How high \_\_\_\_\_ How long \_\_\_\_\_

3. Have tonsils, adenoids, or both been removed? \_\_\_\_\_

If so, when? \_\_\_\_\_

4. Has the child ever been hospitalized? \_\_\_\_\_

Why? \_\_\_\_\_ At what age? \_\_\_\_\_ For how long? \_\_\_\_\_

Please list any other conditions your child has that could affect his or her progress in school.

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## FAMILY AND SOCIAL HISTORY

1. List children and adults who live in the home, other than the child's parents.

Name \_\_\_\_\_ Age \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_

2. Has any member of the family been seen at the Eckelmann-Taylor Speech and Hearing Clinic?

If so, when? \_\_\_\_\_

3. Is your child currently enrolled in therapy? \_\_\_\_\_ If so, where? \_\_\_\_\_