



Speech/Language - Child Case History Form

Name _____ Date _____

Date-of-Birth _____ Age _____ Pronouns _____

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 _____

INSURANCE:

Primary _____ Secondary _____

Policy # _____ Policy # _____

Group # _____ Group # _____

Subscriber Name _____ Subscriber Name _____

Subscriber DOB _____ Subscriber DOB _____

Subscriber Phone Number & Address _____

COMMUNICATION HISTORY

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

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

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

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 the child's communicative behavior?

6. When did you first notice that the child had a communication difficulty?

7. What other communication problems have occurred in your family?

8. At what age did the 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? _____

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 the child's speech? _____
 Can unfamiliar listeners? _____
15. If the child does not speak, how does he/she communicate wants and needs?

16. Does the child's communication behavior change when he/she talks with different people? (mother, father, brother, sister, teacher, friends, strangers, other children)

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

30. What are the child's favorite activities?

31. Describe the child's play with their favorite playmates.

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

- Where? At home ____ Elsewhere ____
- How many times a week is the child in this person's care? _____
- How does this person react to the child's communication difficulty? _____

BIRTH AND DEVELOPMENTAL HISTORY

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

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 list.

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 the 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 the child has that could affect his or her progress in school.

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 the child currently enrolled in therapy? _____ If so, where? _____