



## FAMILY SPEECH & THERAPY SERVICES

# Child Case History

Please complete the following information about your child to assist the Speech-Language Pathologist in evaluating your child. If a question does not apply to your child please mark "N/A". If you are unsure how to answer a question please leave it blank and the Speech-Language Pathologist will discuss it with you at the time of the evaluation. If you have copies of other case histories you have filled out for other providers and would like to use that instead of filling out "another" form, that is fine.

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Diagnoses (of any kind): \_\_\_\_\_  
\_\_\_\_\_

Does your child receive speech therapy services through the school district? Yes/ No  
If yes, how often? \_\_\_\_\_

Name of child's therapist: \_\_\_\_\_ Phone number: \_\_\_\_\_

Describe your concerns regarding your child: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Was this evaluation recommended by another professional? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, by who, and what concerns were shared with you? \_\_\_\_\_  
\_\_\_\_\_

When did you first notice a problem? \_\_\_\_\_  
\_\_\_\_\_

Has your child had previous treatment or evaluation of his or her speech? Yes / No

If yes, by whom? \_\_\_\_\_

What were the results? \_\_\_\_\_

Does your child receive any other therapy? Yes \_\_\_\_ No \_\_\_\_

If yes, what kind and how often? \_\_\_\_\_



Please check yes or no for the following questions. After each question, please write in any comments that you feel would be helpful to us.

	YES	NO	COMMENTS
<b>Prenatal History:</b> Were there any illnesses, injuries, bleeding or any other difficulties before birth?			
Was your child born prematurely or significantly past the due date? If yes, please give weeks and weight?			
Was the delivery breech, caesarean, or other? Please specify.			
Were there any complications with labor or delivery?			
Do you know your child's APGAR scores? If yes, please list.			
Was there a need for oxygen or additional respiratory assistance?			
Were there complications at birth such as jaundice, limpness etc?			
Were there any feeding difficulties? Please specify.			
Was your child bottle fed?			
Was the length of your infant's stay in the hospital unusually long? If yes, why?			
Does your child experience frequent ear infections or fluid in the ears? Approximately how many or how often?			
Has your child ever had PE tubes? If yes, are they still in? In what ear(s)?			
Has your child ever had their hearing tested? If yes, when and what were the results.			
Has your child ever had their vision tested? If yes, when and what were the results.			
Does your child have any allergies?			
Has your child ever been hospitalized or had surgery?			
Are there any other medical concerns? If yes, please list type of concern, severity, duration, and complications.			
Does your child snore or breathe through their mouth?			

## DEVELOPMENTAL HISTORY

How old was your child when he/she:

First babbled	_____	Rolled over	_____
Used their first word	_____	Sat unassisted	_____
Combined words	_____	Crawled	_____
Drank from an open cup	_____	Walked	_____
Ate table foods	_____	Potty Trained	_____

Describe your child's temperament from 0-12 months, (e.g., colicky, lethargic, alert):

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Describe your child's temperament from 12 months to 3 years, (e.g., quiet, busy, easy-going, restless, tantrums):

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## SPEECH/LANGUAGE DEVELOPMENT

How does your child communicate at home (e.g., verbally, gesturally, pictures, sign language, babbles, cries)? \_\_\_\_\_

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Estimate how many words your child uses consistently: \_\_\_\_\_

Estimate the length (# of words) of your child's utterances (single words, 2 or 3 word sentences, short phrases or sentences): \_\_\_\_\_

What is the primary language spoken in the home? \_\_\_\_\_

Are there any other languages the child is exposed to? \_\_\_\_\_

Does your child have any dietary restrictions? Yes / No  
If yes, please describe: \_\_\_\_\_

Can your child understand and follow simple directions? \_\_\_\_\_

Does your child ask "wh" questions (e.g., who, what, where) appropriately? Yes / No

Does your child answer "wh" questions appropriately? Yes / No

Does your child turn their head when their name is said? Yes / No

Does your child play/socialize well with peers? Yes / No

Does your child have difficulty making friends? Yes / No

What percentage (approximately) of what your child says, do you understand? \_\_\_\_\_

What percentage do grandparents understand? \_\_\_\_\_ Unfamiliar people? \_\_\_\_\_

## EDUCATIONAL HISTORY

Is your child in daycare? Yes / No

Is your child in preschool? Yes / No Where? \_\_\_\_\_

What grade is your child in? \_\_\_\_\_ What school? \_\_\_\_\_

Has your child been through preschool screening? Yes / No

Has your child experienced any difficulties in school? \_\_\_\_\_

Has your child received any support services in school, in the past or currently? (e.g., occupational therapy, para support, reading help etc.) \_\_\_\_\_

How do you describe your child's academic skills? \_\_\_\_\_

How do you describe your child's social skills and maturity? \_\_\_\_\_

## FAMILY HISTORY

Please provide the names and ages of your child's siblings: \_\_\_\_\_

Does anyone in your immediate or extended family have any language or learning difficulties? Yes / No If yes, please describe. \_\_\_\_\_

Does anyone in your immediate or extended family have any medical concerns? (e.g., mental illness, cognitive disability, hearing problems, seizure disorders etc.) \_\_\_\_\_

Are there any family circumstances you feel we should know about? (e.g, new baby, divorce, separation, recent death in the family) \_\_\_\_\_

Any Additional Concerns: \_\_\_\_\_ (Please continue on back)

We greatly appreciate your time in completing this form. It will help us to better evaluate your child.

**THANK YOU!!!!!!**