FAMILY SPEECH & THERAPY SERVICES

Child Case History

Please complete the following information about your child to assist the therapist 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 the therapist will discuss it with you at the time of the evaluation.

Name: ______________________________ DOB:__________________ Age:___________

Diagnoses (of any kind): ____

Parents Names: ____

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? ____

Describe your concerns regarding your child: ______________________________________

____

____

Describe your goals for your child:____

____

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

Name of child’s therapist(s): ____

Phone number(s): ____

Has your child had previous treatment or evaluation by a speech or occupational therapist?

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? ____

Is your child followed by any other medical professional? Yes___________ No___________

Yes / No If yes, by whom? ____

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
Prenatal History: Were there any illnesses, injuries, bleeding or any other difficulties before birth? If yes, please specify.			
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? If yes, please specify.			
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 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)? Please provide the name of the ENT that follows your child.			
Has your child ever had their hearing tested? If yes, please list location of testing, date of testing, professional that administered the test and results of the test.			
Has your child ever had their vision tested? If yes, when and what were the results.			
Does your child have any allergies?			
Does your child have any dietary restrictions? If yes, please specify.			
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?			

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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	______________
Used silverware	______________		

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

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

Describe any concerns about your child's dressing/undressing, toileting, or other self care skills:

Does your child have difficulty making friends? Yes / No If yes, please explain ___________________

____

SPEECH/LANGUAGE DEVELOPMENT

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

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 percentage (approximately) of what your child says, do you understand? ______________________

What percentage do grandparents understand? ______________ Unfamiliar people? ________________

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

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

What is the primary language spoken in the home? ____

Are there any other languages the child is exposed to? ____

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EDUCATIONAL HISTORY

Is your child in daycare? Yes / No

Is your child in preschool? Yes / No Where? ___________________________________

Preschool schedule ____

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? _______________________________

____

FAMILY HISTORY

Please list people who reside within the home and ages of 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!!!!!

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