CLERMONT SPEECH & LANGUAGE THERAPY CENTER

Speech-Language Pathology Clinic

CASE HISTORY FORM-Child

*Please fill out this form as completely as possible, especially the questions marked with an asterisk * If you need more space, write on the last page, or add a sheet. Please call (352) 272-9750 if you have additional questions regarding these forms.*

Date: _____

Person filling out this form: _____ Relationship to child: _____

Identifying Information

*Child's name: _____ *Birth date: _____ Age: _____ Gender: F M

*Parents or Guardians: _____

Phone: (home) _____ (cell) _____ (work) _____

Best time to call: _____ Email: _____

Address: _____

City: _____ State: _____ ZIP: _____

*Reason for referral: _____ Referring person: _____

History of Problem

*Describe present problem: _____

_____

_____

Who noted present problem? _____ When? _____

*What is your child's reaction to the problem? _____

_____

*How does the family react to the problem? _____

_____

Has there been any significant change in last six months? _____ If so, what? _____

_____

*How well is your child understood by: (i.e., what percentage of the time)

Mom: _____ Dad: _____ Younger siblings: _____ Older siblings: _____

Other children: _____ Extended family: _____ Unfamiliar adults: _____

*Describe what it is like to have a conversation with your child: _____

_____

_____

_____

*Any previous assessments? Y N Where? _____ By whom? _____

*What kind? _____

*What were the results? _____

*Which tests were given? _____

*Any previous therapy? Y N Where? _____ With whom? _____

Health History

Birth History

What was the length of the pregnancy?_____

*Were there any illness or accidents during pregnancy? (explain)_____

*Were drugs or alcohol used during pregnancy? (aspirin and/or other medication) Y N If so, what? _____

_____

What was the length of labor?_____ *Any difficulties at birth, including Caesarian?(describe):_____

_____

Were drugs used?_____ Instruments?_____ Bruises to head?_____

What was the mother's age:_____ Mother's health at time of pregnancy and birth was:_____

_____

What was the final Apgar score? _____ Any jaundice? Y N cyanosis? Y N Rh incompatibility factors? Y N

Medical History

*Please check if your child has had any of the following (and if so, at what age):

____ Seizures	____ High fevers	____ Measles	____ Mumps
____ Chicken pox	____ Whooping cough	____ Diphtheria	____ Croup
____ Pneumonia	____ Tonsillitis	____ Meningitis	____ Encephalitis
____ Rheumatic fever	____ Tuberculosis	____ Sinusitis	____ Chronic colds
____ Enlarged glands	____ Thyroid	____ Asthma	____ Heart trouble

Please explain any checked items here:_____

_____

Are immunizations current?_____Current general health:_____

**Has your child had any earaches/ear infections? Y N Please explain here: _____

_____

Allergies? (Describe) _____

Any other serious or recurrent illnesses?_____

Any operations?_____

Any accidents?_____

Any medications? (Past) _____ (Current) _____

Vision problems?_____Treatment:_____

*Hearing difficulties: _____Treatment:_____

Dental problems?_____Treatment:_____

Other Medical History: _____

_____

_____

****If your child has had chronic ear infections and/or had tubes placed in his or her ears, please attach or have a statement sent from your doctor regarding dates and results of treatment.**

Personal Medical Information

Personal Primary Physician: _____ Date of last visit: _____

Address or Location: _____

Ongoing Medical Care (Describe): _____

Physician's Name: _____ City: _____

Current Medications: Dosage: Physician: Location:

_____

_____

Chronic Health Problems (Asthma, Congenital Defects, etc.): _____

Handicaps (Describe, if any): _____

Developmental History

Age when child: (If you can't remember specific time, please indicate if it occurred at the expected time or was delayed)

sat up alone _____ crawled _____ walked _____ toilet trained _____ dressed self _____

tied shoes _____ fed self independently _____ Is the child left or right handed? _____

Attention span-for self-directed activities: _____

*Attention span for adult-directed activities: _____

Eating and sleeping patterns: _____

Does your child respond to: Light? _____ Sound? _____ People? _____

Does your child: Play with others? _____ Who? _____

Eat and sleep well? _____ Cry appropriately ? _____ Laugh? _____ Smile? _____

Make wants known? _____ How? _____

Does your child show unusual behavior (explain)? _____

Language Development

Language(s) spoken in home: _____

*Age when your child spoke first word: _____ *combined words: _____ *spoke in sentences: _____

*What was your child's first word(s)? _____ *first sentence? _____

*Which sounds (if any) are incorrect? _____

*How many words can your child say? (list if fewer than fifteen) _____

_____

*How long are your child's sentences? _____

*Does your child have any difficulty understanding you? (describe) _____

*Does your child have difficulty following directions? (describe) _____

*Any speech or hearing problems in the immediate or extended family (explain)? _____

_____

Social Development

Names and ages of siblings: _____

_____

Other adults living in the home: _____

Moves prior to age 10:_____

Has your child attended day care?_____ Nursery School? _____

Number of regular playmates:_____ Ages: _____ Genders:_____

Activities shared with parents and siblings:_____

*How does your child handle frustration:_____

conflict:_____ separation:_____

Regular responsibilities:_____

Favorite places:_____ people:_____ toys:_____

snacks:_____ activities:_____ TV programs: _____

What motivates your child most?_____

What discipline methods work best?_____

School History

School experience:_____

How does your child's teacher describe his/her performance?_____

_____

Has the teacher expressed any concern? If so, what?_____

Other

*What do you hope to have happen as a result of this evaluation?_____

*Does the report need to be sent to specific agencies?_____ Where?_____

_____

*Anything else you would like us to know?_____

_____

_____

_____

_____

_____

*** PLEASE MAIL THESE COMPLETED FORMS, ALONG WITH ANY OTHER APPLICABLE CASE HISTORY FORMS (EX. VOICE, FLUENCY, ACCENT REDUCTION) TO:**

CLERMONT SPEECH & LANGUAGE THERAPY CENTER

ATTN: PATRICK WHITE

1004 EAST AVENUE

CLERMONT, FL 34711

PLEASE SEND RELEVANT REPORTS AND INFORMATION FROM OTHER AGENCIES IN A SEPARATE ENVELOPE.