

**SPEECH-LANGUAGE-HEARING CASE HISTORY FORM**

# Identifying and Family Information:

Child’s Name: Birthdate: Sex: M F

Father’s Name: Daytime Phone: Address: Cell Phone:

E-mail:

Mother’s Name: Daytime Phone: Address: Cell Phone:

E-mail: Doctor’s Name: Doctor’s Phone:

# Child lives with (check one):

Birth Parents

Adoptive Parents

Foster Parents

Parent and Step-Parent

One Parent

Other

# Other children in the family:

Name Age Sex Grade Speech/Hearing Problems

# Child’s race/ethnic group:

Caucasian, Non-Hispanic

Native American

Hispanic

Asian or Pacific Islander

African-American

Other

# Is there a language other than English spoken in the home? Yes No

If yes, which one? Does the child speak the language? Yes No

Does the child understand the language? Yes No

Who speaks the language? Which language does the child prefer to speak at home?

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**Speech-Language-Hearing**

Do you feel your child has a speech problem? Yes No

If yes, please describe.

Do you feel your child has a hearing problem? Yes No

If yes, please describe.

Has he/she ever had a speech evaluation/screening? Yes No

If yes, where and when? What were you told?

Has he/she ever had a hearing evaluation/screening? Yes No

If yes, where and when? What were you told?

Has your child ever had speech therapy? Yes No

If yes, where and when? What was he/she working on?

Has your child received any other evaluation or therapy (physical therapy, counseling, occupational therapy, vision, etc.)? Yes No

If yes, please describe.

Is your child aware of, or frustrated by, any speech/language difficulties?

What do you see as your child’s most difficult problem in the home?

What do you see as your child’s most difficult problem in school?

**Birth History**

Was there anything unusual about the pregnancy or birth? Yes No

If yes, please describe.

How old was the mother when the child was born?

Was the mother sick during the pregnancy? Yes No

If yes, please describe.

How many months was the pregnancy?

Did the child go home with his/her mother from the hospital? Yes No

If child stayed at the hospital, please describe why and how long.

Did the child ever use a pacifier? Yes No

Does the child still use a pacifier? Yes No

If no, please indicate at what age the child no longer utilized a pacifier? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History**

Has your child had any of the following?

adenoidectomy encephalitis seizures

allergies flu sinusitis

breathing difficulties head injury sleeping difficulties

chicken pox high fevers thumb/finger sucking habit

colds measles tonsillectomy

ear infections meningitis tonsillitis

How often? mumps vision problems

ear tubes scarlet fever

Other serious injury/surgery:

Is your child currently (or recently) under a physician’s care? Yes No

If yes, why?

Please list any medications your child takes regularly:

Please list any known allergies:

**Developmental History**

# Please tell the approximate age your child achieved the following developmental milestones:

sat alone grasped crayon/pencil

babbled said first words

put two words together spoke in short sentences

walked toilet trained

# Does your child...

choke on food or liquids? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

currently put toys/objects in his/her mouth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

brush his/her teeth and/or allow brushing? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

use a spoon? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

type of cup used (circle all that apply): sippy open cup 360 straw other? \_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Speech-Language-Hearing**

# Does your child...

repeat sounds, words or phrases over and over?

understand what you are saying?

retrieve/point to common objects upon request (ball, cup, shoe)?

follow simple directions (“Shut the door” or “Get your shoes”)?

respond correctly to yes/no questions?

respond correctly to who/what/where/when/why questions?

# Your child currently communicates using...

body language.

sounds (vowels, grunting).

words (shoe, doggy, up).

2 to 4 word sentences.

sentences longer than four words.

other .

# Behavioral Characteristics:

cooperative restless

attentive poor eye contact

willing to try new activities easily distracted/short attention

plays alone for reasonable length of time destructive/aggressive

separation difficulties withdrawn

easily frustrated/impulsive inappropriate behavior

stubborn self-abusive behavior

**School History**

# If your child is in school, please answer the following:

Name of school and grade in school:

Teacher’s name:

Has your child repeated a grade?

What are your child’s strengths and/or best subjects?

Is your child having difficulty with any subjects?

Is your child receiving help in any subjects?

**Additional Comments**

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