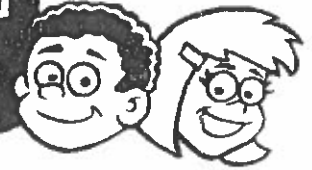


SPEECH-LANGUAGE-HEARING CASE HISTORY FORM



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 Foster Parents One Parent
 Adoptive Parents Parent and Step-Parent Other _____

Other children in the family:

Name	Age	Sex	Grade	Speech/Hearing Problems
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Child's race/ethnic group:

- Caucasian, Non-Hispanic Hispanic African-American
 Native American Asian or Pacific Islander 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? _____

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. _____

Medical History

Has your child had any of the following?

- | | | |
|---|--|---|
| <input type="checkbox"/> adenoidectomy | <input type="checkbox"/> encephalitis | <input type="checkbox"/> seizures |
| <input type="checkbox"/> allergies | <input type="checkbox"/> flu | <input type="checkbox"/> sinusitis |
| <input type="checkbox"/> breathing difficulties | <input type="checkbox"/> head injury | <input type="checkbox"/> sleeping difficulties |
| <input type="checkbox"/> chicken pox | <input type="checkbox"/> high fevers | <input type="checkbox"/> thumb/finger sucking habit |
| <input type="checkbox"/> colds | <input type="checkbox"/> measles | <input type="checkbox"/> tonsillectomy |
| <input type="checkbox"/> ear infections | <input type="checkbox"/> meningitis | <input type="checkbox"/> tonsillitis |
| How often? _____ | <input type="checkbox"/> mumps | <input type="checkbox"/> vision problems |
| <input type="checkbox"/> ear tubes | <input type="checkbox"/> 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: _____

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?

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:

- | | |
|--|--|
| <input type="checkbox"/> cooperative | <input type="checkbox"/> restless |
| <input type="checkbox"/> attentive | <input type="checkbox"/> poor eye contact |
| <input type="checkbox"/> willing to try new activities | <input type="checkbox"/> easily distracted/short attention |
| <input type="checkbox"/> plays alone for reasonable length of time | <input type="checkbox"/> destructive/aggressive |
| <input type="checkbox"/> separation difficulties | <input type="checkbox"/> withdrawn |
| <input type="checkbox"/> easily frustrated/impulsive | <input type="checkbox"/> inappropriate behavior |
| <input type="checkbox"/> stubborn | <input type="checkbox"/> self-abusive behavior |

