Saint Xavier University
Ludden Speech and Language Clinic

CHILD CASE HISTORY FORM

Any client applying for services at the Ludden Speech and Language Clinic is required to answer all questions as completely and accurately as possible.

If you have any other information from other professionals, such as medical records or school evaluations, please forward copies of those documents along with this case history form.

**Please note this is not a peanut-free facility.

The Ludden Speech and Language Clinic maintains confidentiality of all client records, including any documentation which you provide from other facilities.

GENERAL INFORMATION: (Print)

Child's Legal Name:_____ Date: _____

Child's Preferred Name (if different): _____

Child's Preferred Gender Pronouns: _____

Date of Birth: _____ Age: _____

Address:_____
(Street) City/State ZIP Code

School: _____ Grade or Type of Class: _____

Child Language (Please check one): ❑ Monolingual ❑ Bilingual ❑ Multilingual

Caregiver(s) Language (Please check one): ❑ Monolingual ❑ Bilingual ❑ Multilingual

What language or languages are spoken at home? _____

FAMILY INFORMATION

Primary Caregiver Name: _____Email: _____

Primary Phone: _____ Secondary Phone:_____

Primary Caregiver Preferred Gender Pronouns:_____

Secondary Caregiver Name: _____ Email:_____

Primary Phone: _____ Secondary Phone:_____

Secondary Caregiver Preferred Gender Pronouns: _____

Brothers and Sisters (names and ages): _____

REFERRAL INFORMATION

Referred By: _____

Profession of Person or Relationship to Client: _____

PRENATAL AND BIRTH HISTORY

During pregnancy, did the mother experience any unusual illnesses or accidents, or require any medication?

Length of Pregnancy: _____ Length of Labor: _____Birth Weight: _____

Type of delivery (Please check one): ❑ Vaginal ❑ Caesarian

Any difficulty latch issues with breast feeding or bottle feeding?
(Please check one): ❑Yes ❑No

Did your child experience any unusual conditions immediately following birth
(Please check all that apply)?

❑ Difficulty Breathing ❑ Feeding/Sucking ❑ Jaundice ❑ Reflux

❑ Low Muscle Tone ❑ Body Temperature ❑ Choking ❑ GI Issues

Other _____

**Please provide more information on any items checked above:

MEDICAL HISTORY

Pediatrician: _____ Telephone: _____

Provide approximate ages at which your child experienced any of the following illnesses or conditions. Please state N/A, if not applicable:

Allergies_____ Asthma _____ Chicken Pox _____

Colds _____ Croup _____ Dizziness _____

Draining Ear _____ Ear Infections_____ Tonsillitis _____

Encephalitis_____ German Measles_____ Influenza_____

Headaches_____ High Fever _____ Seizures _____

Mastoiditis_____ Measles_____ Meningitis _____

Mumps_____ Pneumonia_____ Head Injury _____

Sinusitis _____ Tinnitus_____ RSV _____

Please provide more information on any items checked above:

Has your child had any surgeries, accidents or hospitalizations? If so, what type and when?

Does your child have a medical diagnosis (e.g., autism spectrum disorder, cerebral palsy, Down syndrome, hearing loss)? If so, please specify and provide what professional provided the diagnosis.

Is your child taking any medications? If so, please list.

Has your child had any negative reactions to medication? Please describe.

Does your child have any known allergies?

DEVELOPMENTAL HISTORY

Provide the approximate age at which your child began the following activities:

Crawl:_____ Sit: _____ Stand:_____ Walk: _____

Feed Self:_____ Dress Self: _____ Use Toilet: _____

SPEECH AND LANGUAGE:

Please describe your concerns regarding speech, language, and hearing:

RECEPTIVE LANGUAGE (check all that apply)

My child understands:

- ❑ single words
- ❑ sentences
- ❑ routine requests (e.g., sit down, stop)
- ❑ yes/no questions
- ❑ wh-questions (e.g., where, when, who)
- ❑ conversation

EXPRESSIVE LANGUAGE

At what age did your child:

Babble? _____Say his/her first word?_____

Combine words? _____Use sentences?_____

My child currently uses the following modes of communication (check all that apply):

- ❑ gestures
- ❑ sign language (about how many _____)
- ❑ words (about how many _____)
- ❑ phrases
- ❑ sentences
- ❑ conversation

When did you become concerned about your child's speech?

Is there anything you do that seems to help your child when they are experiencing communication difficulties?

Does your child appear to be aware of their communication difficulties?

Is there any history of speech, language or hearing difficulties in your family?
If so, please describe.

Has your child's teacher expressed any concerns regarding communication or speech?
If so, please describe.

Have any other speech-language pathologists seen your child? If so, who and when?
What were their conclusions or suggestions? (Please include reports with application.)

If your child received past services through the Early Intervention Program, was your child discharged from services before turning 3 years old? What were the recommendations from the Early Intervention team prior to discharge?

Have any other specialists (e.g., psychologists, neurologists, physicians, therapists, special education teachers, audiologists) seen your child? If so, indicate type of specialist, when your child was seen, and any conclusions or suggestions.

Is your child currently receiving any speech-language, physical or occupational therapy? If so, where?

Does your child have an Individualized Education Plan (IEP) in the school setting? If so, please send a copy of the IEP with this application.

Please include any additional reports or information that might be helpful in the evaluation and/or remediation of your child's speech/language problem.

**In order to be considered for an evaluation or treatment, this form must be completed and submitted in its entirety.

Person completing form: _____

Are you the Parent ❑or Legal Guardian ❑? (Please check one)

Signature: _____Date: _____

Please note that this form must be signed by a child's parent or legal guardian.