GIFT OF GAB
SPEECH THERAPY, LLC

Pediatric Speech & Language Case History Form

1. Background Information

Child's Name:
_____

Date of Birth:
_____

Age:
_____

Parent/Guardian Name(s):
_____

Address:
_____

Phone:
_____

Email:
_____

Date Completed:
_____

Who referred your child for speech/language services?
_____

Reason for referral (main concerns):
_____

Who does the child live with?
_____

Languages spoken at home:
_____

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Primary language of the child:
_____

2. Medical History

Birth history: (check one) [ ] Full term [ ] Premature - weeks early:____
_____

Birth weight:
_____

Pregnancy/delivery complications:
_____

Serious illnesses, injuries, or hospitalizations:
_____

Ear infections: (check one) [ ] None [ ] Occasional [ ] Frequent
_____

Tubes placed? (check one) [ ] Yes [ ] No
_____

Vision: (check one) [ ] Normal [ ] Concerns
_____

Hearing: (check one) [ ] Normal [ ] Concerns
_____

Current medications:
_____

Allergies:
_____

3. Developmental History

Sat alone (age):
_____

Crawled:
_____

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Walked:
_____

Spoke first words:
_____

Spoke in short phrases:
_____

Toilet trained:
_____

Feeding/swallowing difficulties (check one) [ ] Yes [ ] No:
_____

If yes, describe:
_____

Drooling excessively (check one) [ ] Yes [ ] No:
_____

4. Speech and Language

How does your child communicate? (check all that apply): [ ] Gestures [ ] Sounds [ ] Words [ ] Phrases [ ] Sentences

Do family members understand your child's speech? [ ] Always [ ] Sometimes [ ] Rarely
_____

Do others understand your child's speech? [ ] Always [ ] Sometimes [ ] Rarely
_____

Has your child had speech/language therapy before? [ ] Yes [ ] No
_____

If yes, where and when?
_____

Child's strengths and favorite activities:
_____

5. Educational & Social Information

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Preschool/School:
_____

Teacher's name:
_____

Grade:
_____

Has your child had educational testing or an IEP? [ ] Yes [ ] No:
_____

How does your child get along with peers? [ ] Very well [ ] Average [ ] Needs support:
_____

Behavioral or attention concerns (if any):
_____

6. Family & Home Environment

Family history of speech, language, or hearing difficulties? [ ] Yes [ ] No:
_____

If yes, describe:
_____

Anything else the therapist should know:
_____

Parent/Guardian Signature:
_____