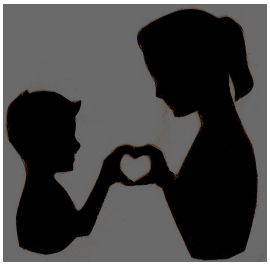

Communication Connection Speech Services
327 N. 7th Street #3, Grand Junction, CO 81501
Phone: (970) 812-0167 Fax: (970) 241-7767
Email: RachelMaySLP@communication-connection.com
Website: www.Communication-Connection.com
Twitter: @RachelMaySLP
Rachel L. May, M.A., CCC-SLP
Speech Language Pathologist
ASHA Certified

Dear Parents and/or Caregivers,

Thank you for your interest in our clinic. Attached is a child case history form for speech and language services. Complete and return the form to our office as soon as possible. Include any additional information or copies of records regarding any previous evaluations or services.
When we receive your completed case history form your child's name will be scheduled. Your position to be scheduled is determined by the date that we receive the form.
Our staff will contact you to schedule your first appointment. If you have any questions, please contact us.

Very Truly Yours,

Rachel L. May, M.A., CCC-SLP
ASHA Certified Speech/Language Pathologist

COMMUNICATION CONNECTION SPEECH SERVICES

CHILD CASE HISTORY FORM

THIS FORM IS TO BE FILLED OUT AND RETURNED TO THE CLINIC BEFORE AN EVALUATION IS SCHEDULED

I. Identification

Name _____ Age_____ Birthdate _____
Address_____ Email: _____
City _____ Zip_____ Phone_____
School _____
Referred by _____ Address _____
Reason for Referral_____
Physician_____ Phone_____
Other doctors (dentists /orthodontists/ psychologists) that provide care to this child
Name Specialty City

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

II. Family

Mother _____Age_____ Occupation _____
History of Speech, Language, or Hearing Problems Yes _____ No _____
If "yes" please explain._____
_____
Father _____Age_____ Occupation _____
History of Speech, Language, or Hearing Problems Yes _____ No _____
If "yes" please explain. _____
_____
List names and ages of brothers and sisters:
_____ Age: _____
_____ Age: _____
_____ Age: _____

Is there a family history of any of the following?

Family Member		Family Member	
Hearing loss	_____	Cleft palate	_____
Speech problem	_____	Seizure disorder	_____
Prematurity	_____	Mental illness	_____
Blindness	_____	Alcoholism	_____
Malformation of the head, neck, or ears	_____	Delayed motor development	_____
Educational Difficulties	_____	Low birth weight	_____
Drug use	_____	Other	_____

Child living with both parents_____ If no, whom does child live with _____
Have there been any of the following major changes in the family during the last year?
_____ change of address _____ accident or illness _____ divorce/ marriage
_____ parent separation _____ death of a family member _____ birth/ adoption
Does anyone in the home smoke? Yes _____ No _____

III. Birth History

Mother's health during pregnancy (note special conditions such as mumps, German measles, x-rays, serious accidents, etc.) _____How long was labor? _____
Length of pregnancy_____ Birth weight of infant_____
Anything unusual about the condition of the infant at birth: Blue Baby___ Lack of Oxygen__

IV. Developmental History

Has your child had any feeding difficulties? Check each item that applies.

_____ Sucking or nursing
_____ Excessive length of time to drink bottle
_____ Regurgitation of liquids or solids through the nose
_____ Difficulty chewing or swallowing meats
_____ Choking and/or gagging

Does your child choke while eating? _____ Yes _____ No
If "yes," on what foods? _____
Is your child a picky eater? _____ Yes _____ No
If "yes," what foods does s/he prefer? _____
Describe any feeding problems your baby experienced during the first three months of life.
_____
_____
Does your child drool more than other children his/her age? _____ Yes _____ No
Did your child have difficulty gaining weight as an infant? _____ Yes _____ No
Describe any early abnormalities of response to light, sound and movement _____
_____
_____
At approximately what age did your child achieve the following motor milestones?

Head support _____	Reach & grasp _____	Sitting alone _____
Crawling _____	Standing alone _____	Walking alone _____
Climbing stairs ____	Finger food _____	Eat with a spoon____
Potty trained _____	Undresses self _____	

Child's coordination normal? _____ fair?_____ poor?_____
Right or left handed? _____
At what age did handedness develop? _____
Did anyone try to influence handedness? (describe) _____
Any abnormalities in early physical development? _____
_____
_____

V. Medical History

Childhood illnesses and injuries. List: Illness, age, amount of fever, after-effects (if any).
Ear aches_____
Ear drainage _____
Pneumonia _____
Convulsions _____
Measles _____
Chickenpox _____
Frequent colds _____
Bronchitis_____
Allergies (describe) _____
Asthma_____
Enlarged adenoids _____
Tonsillitis _____
Concussions_____
Serious Injuries _____
Other (describe) _____
Operations (describe) _____
If your child has had fevers, how long do they last? _____
Check any of the following drugs that your child has taken: Quinine____ Streptomycin_____
Nicotine (in utero)_____ Frequent aspirin _____ Neomycin_____

Name any medicines the child is currently taking: _____
_____

VI. Play Behaviors

Which of the following describes the type of play your child likes to engage in the most often?

____ putting toys in mouth	____ banging toys together	____ throwing toys
____ shaking toys	____ pushing/pulling toys	
____ appropriate use of objects	____ uses one object for another	
____ acting out familiar routines	____ role-playing	_____ make believe play
____ games with rules	____ rough and tumble play	_____ looking at books

What is the average length of time your child can stay playing at one activity? _____

What activities seem to hold your child's attention for the longest period of time?

_____

Which activities seem to hold your child's attention for the shortest period of time? _____

_____

Is your child's play easily distracted by any of the following?

_____ Visual stimuli (i.e. other toys or objects)
_____ Auditory stimuli (i.e. voices, sounds outside, the TV)
_____ Nearby activities
_____ Other people in the room

Whom does your child prefer to play with?

mother father brother/sister self other child other adult

VII. Personality

What are the child's chief interests? _____

_____

How often does the child exhibit the following characteristics: (often, sometimes, never)

nervous _____	day dreaming_____
sleeping problems_____	shyness _____
bed wetting _____	aggressive _____
thumb sucking_____	inferiority complex _____
nightmares_____	jealousy_____
nail biting _____	fearful _____
destructive_____	showing off _____
temper tantrums_____	quiet_____
co-operative_____	selfish _____
eating problems_____	leadership _____
happiness_____	friendliness w/ adults _____
stealing _____	friendliness w/ children_____
explosive behavior _____	unusual fears (describe) _____

_____

Describe any discipline problems you have with your child._____

_____

What problems does the child have, if any, in school? _____

_____

VIII. Educational History

Preschool

Educational Setting	Location/School	Teacher/Therapist
Child Care Facility		
Early Childhood Classes		
Early Intervention (0-3)		

How often does your child attend classes?

_____ daily _____ 4 times per week _____ 3 times per week

_____ 2 times per week _____ days _____ full day

Does your child's developmental performance seem to interfere with his/her school performance? _____ Yes _____ No

Have teachers expressed any concerns about your child's learning behavior? ___ Yes ___ No

If so please describe.

_____

School Age

School: _____ Grade: _____ Principal: _____

Teacher(s): _____ Speech/ Language Clinician:

_____

Type of classroom: Traditional Open Transdisciplinary Other: _____

What are your child's average grades?

Subject	Grade
Math	
Reading	
Spelling/ Writing	
Science	
Social Studies	

Did your child fail any grades? _____ Did your child skip any grades? _____

Did your child attend preschool/ nursery school? ___ Age? ___ Kindergarten? ___ Age? ___

Is your child frequently absent from school? If so, why? _____

How does your child feel about school and his or her teacher(s)? _____

_____

Does your child receive special reading or language arts services? ____ If so, please explain:

_____

_____

Does your child exhibit any learning style preference? visual auditory both

If "yes," please explain. _____

_____

IX. Speech History

What languages are spoken at home? _____

Which are spoken by the child? _____

Which are understood by the child? _____

Please indicate when your child first demonstrated the following.

Age	Behavior	Age	Behavior
_____	cooing, pleasure sounds	_____	single words
_____	babbling (ba-ba, da-da, etc)	_____	phrases (go bye, more juice)
_____	jargon (talking own special language)	_____	short sentences

What is the primary method(s) your child uses for letting you know what s/he wants?

_____ looking at objects _____ pointing at objects _____ gestures
_____ crying _____ vocalizing/ grunting _____ physical manipulation
_____ single words _____ 2-3 word combinations _____ sentences

Which of the following best describes your child's speech?

_____ easy to understand
_____ difficult for parents to understand
_____ difficult for others to understand
_____ almost never understood by others
_____ different from other children of the same age

Which of the following best describes your child's reaction to his/her speech?

_____ is easily frustrated when not understood
_____ does not seem aware of speech/ communication problem
_____ has been teased about his/her speech
_____ tries to say sounds or words more clearly when asked
_____ is successful at saying sounds or words more clearly when s/he tries

Does your child have difficulty producing certain sounds? _____ Yes _____ No
If "yes," which ones?

_____

Does your child hesitate and/or repeat sounds or words? _____ Yes _____ No
Does your child "get stuck" when attempting to say a word? _____ Yes _____ No
Do you have concerns about your child's voice? _____ Yes _____ No
Which of the following do you think your child understands?

_____ his/her own name _____ names of body parts _____ family names
_____ names of objects _____ simple directions _____ complex directions
_____ conversational speech

What is the parents' reaction to child's speech? _____
_____
What is the child's attitude toward own speech? _____
When was speech difficulty first noticed? _____
By whom? _____
Describe the child's present speech_____
_____
What changes have you noticed in the child's speech since the difficulty was first noticed?

_____

X. Hearing

Describe any hearing difficulties_____

_____

Has child had hearing tested? _____ When? _____ By whom? _____

Does the child have a hearing aid? _____ Does s/he use it? _____

Listening Habits:

Ability to hear on the telephone_____ ear used_____

Radio/stereo/TV _____

Ability to hear in groups_____

Ability to understand in quiet_____

Ability to understand in noise_____

Ability to locate direction of sounds_____

XI. Previous Speech Treatment

Has your child received speech treatment? _____ How long?_____ By whom?

_____

Results_____

XII. Statement of Problem

Please state in your own words what you think the child's problem is, and what you think might have caused it. _____

_____

_____

_____

When did you first notice the problem? _____

_____

Whom did you first tell about this problem? _____

What was this person's response? _____

What is your child's awareness of/ reaction to this problem? _____

_____

How do you and other family members react to this problem? _____

_____

What information do you hope to gain from this evaluation, and what specific questions or areas do you wish to address? _____

_____

Completed by: _____

(Sign your name)

Date:

_____