



CASE HISTORY for CHILDREN

Our evaluation of your child's hearing, speech, and language will depend upon information about his/her speech, hearing, language development, and medical history. Please fill out this form as completely as possible and return it to the email address below as soon as possible.

Email: admin@timetosproutspeechtherapy.com

NOTE: All information is kept completely confidential

I IDENTIFICATION

Person completing form: _____ Relationship to patient: _____

NAME: _____

Address: _____

Mother's Name: _____ Father's Name: _____

DOB: _____ PHONE: _____ (Home)

PHONE: _____ (Work)

Male / Female RACE: _____ PHONE: _____ (Cell)

School: _____ Grade: _____

Referred by: _____ Student preferred hand: _____ R _____ L

Name & Address of Doctor: _____

II. BACKGROUND INFORMATION

Describe the problem _____

When was the problem first noticed? _____

Who first noticed the problem? _____

What do you think caused the problem? _____

What changes in your child's language, speech, or hearing have you noticed since that time:

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Have you consulted other persons about the problem? _____

If Yes, Whom have you consulted? _____

What was the evaluation of this consultation? _____

Has this child ever had speech or language therapy? _____

If Yes, When and Where? _____

A. Hearing / Speech / Language History

1. What language is spoken at home? _____

2. At what age did this child babble and coo? _____

3. When did this child say his/her first word? _____

4. When did this child begin to use two-word phrases? _____

5. When did this child begin to use sentences? _____

6. How well can he/she be understood by parents? _____

7. Sisters or brothers? _____

8. Strangers or relatives? _____

9. How well can he/she be understood by friends? _____

10. How many words are in your child's vocabulary/ sign language?

11. Which does this child prefer to use: Sentences _____ Phrases _____

12. One or two words _____ Sounds _____ Gestures _____

13. Do you question your child's ability to understand directions and conversation? _____

14. Why do you question your child's ability to understand? _____

15. Do you question your child's ability to express himself? _____

16. Why? _____

17. Does your child hesitate, "get stuck", repeat, or stutter on sounds or words? _____

18. If so, describe. _____

19. How often? _____

20. Does your child's voice sound hoarse? _____

21. Does your child's voice sound low-pitched? _____

22. Does your child's voice sound nasal? _____

23. Do you think your child hears adequately? _____ Do you think that his

hearing changes from day to day? _____ What do you think may have caused his/her

hearing problem? _____

24. Does your child wear hearing aid(s)? _____ What kind _____ At what age did

he begin to wear hearing aid(s)? _____

25. Who recommended the hearing aide? _____

26. Does he/she like to wear the aid(s)? _____

27. Do you think that his hearing changes from day to day? _____

28. Does your child use any other assistive listening device at home? _____

29. What kind? _____

30. Does your child use an auditory training device at school? _____

What kind? _____

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Please Check reason(s) for evaluation

- Fine Motor Sensory Mobility Gross Motor
 Self Care Skills Handwriting Overactive Under-active
 Difficulty with transitions Difficulty following directions
 Difficulty with self regulation skills Difficulties with attending to tasks
 Difficulties with sitting at table for tasks for a reasonable length of time
 Have aversions to touch, sight, sounds, or smells
 Other Please check the reason(s) for evaluation Describe your current concerns (Please fill out this form as completely as possible).

Current Skills - **Please check box**

Does your child seem awkward, uncoordinated, or clumsy?

Does your child lose their balance or fall easily?

Your child currently communicates using...

Does your child display a hand preference? If so, which hand? Left Right Able to perform fine motor skills? Choke on food or liquids? Currently put toys/objects in his/her mouth? Exhibit drooling?

Indicate any/all areas of difficulty:

- Zippers/Buttons Hopping/Jumping Handwriting Lacing/Tying Shoes
 Impulsivity Overly cautious Avoids getting messy Throwing ball overhand
 Walking/Running Walking up/down stairs Crossing midline Copying shapes Cutting
 Balance/Coordination Activity seeking Activity avoidance (i.e. swings, slides) Sensory Preferences/Avoidances (textures, sounds, light) Vision problems Using utensils
Difficulty completing tasks Exhibits toe walking?

Other

Have you consulted other people about the problem? _____

If Yes, Whom have you consulted? _____

What was the evaluation of this consultation? _____

Has this child ever had speech or language therapy? _____

If Yes, When and Where? _____

A. History of Problem

1. What problem(s) brings you here today? _____

2. When did this problem begin? _____

3. Did this occur gradually or suddenly?

Please Describe _____

4. Were he/ she hospitalized for this condition? Yes/No. If yes when, for how long, & where _____

5. Since this problem began have his/her symptoms _improved ___worsened ___stayed the same.

6. What Diagnostic tests/ procedures have you undergone for this problem (ie x-rays, MRI, EMG, surgery)? _____ Please list results/findings:

7. Have you received any other treatment for this condition (i.e. OT, PT, injections). Yes/ No. If yes describe type of treatment, dates received

8. What activities increase his/her symptoms:

9. What activities decrease his/ her symptoms:

10. What is her/her pain level:

Pain at Rest _____

Pain With Activity _____ 0 1 2 3 4 5 6 7 8 9 10

YES/ No Pain Unbearable Pain Where is your Pain

Quality of Pain is: ___sharp ___dull ___throbbing ___numbness ___tingling

___shooting ___burning ___other _____ Frequency of Pain: ___constant

___(76-100%) ___frequent (51-75%) ___occasional ___(26-50%)

___rarely (25% or less) Please list all medications you are currently taking

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B. Developmental/Medical History

Child is our _____ biological, _____ adopted, _____ foster child.
Number of pregnancies mother has had _____, which pregnancy was this child _____.

1. Did mother have any of the following? Which month? Was hospitalization necessary?

- | | | |
|---|---|--|
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Virus infection | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> German measles – Rubella | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Heart condition | <input type="checkbox"/> Convulsions |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Excessive weight gain/loss | <input type="checkbox"/> Thyroid condition |
| <input type="checkbox"/> Toxemia | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Rh Negative blood |
| <input type="checkbox"/> X-rays | | |

Medications (what kind?) _____

- Accidents _____
- Anesthetics _____ Surgeries (year) _____
- Drinking alcohol _____ Smoking _____

2. What was the length of the pregnancy? _____
3. What was the length of the hard labor? _____
4. What was the type of delivery? _____ Vertex (head presentation) _____ Breech
_____ Caesarian _____ Dry _____ Other? _____
5. Were there any unusual problems at birth? _____ If so, Describe _____

6. Were forceps used? _____ Bruises? _____

7. Birth weight? _____

8. Apgar score at 1 minute _____ at 5 minutes _____

9. Were there any health problems during the first two weeks of infant life?

Jaundice	Transfusion	Blueness
Oxygen	Difficulty breathing	Feeding difficulty
Convulsions	Intravenous or intramuscular fluids	
Incubator or isolate	Cry (strong, weak, high)	Infection
Hemorrhage	Tube fed	

10. How long did the child remain in the hospital?

11. Is there any other information about the mother or baby which can help us evaluate this child? _____

12. Note the ages when the following occurred:

_____ Hold head erect	_____ Follow objects with eyes
_____ Reach for objects	_____ Roll over with from back to stomach
_____ Sit Unsupported	_____ Crawl
_____ Feed self with spoon	_____ Stand alone
_____ Walk Alone	_____ Dress Self
_____ Toilet Trained	

Is the child well coordinated or clumsy?

Does a child lose balance or fall easily?

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13. At what ages did any of the following or surgeries occur? Indicate severity and temperature.

	Age	Severity & Temperature
Whooping Cough		
Mumps		
Scarlet Fever		
Measles		
Chicken Pox		
Pneumonia		
Diphtheria		
Croup		
Influenza		
Headaches		
Sinus		
Meningitis		

Rickets		
Rheumatic Fever		
Polio		
Dental Problems		
Ear Infections		
Draining Ears		
P.E. Tubes Insertion		
Tonsillectomy		
Adenoidectomy		
Allergies		
Epilepsy		
Encephalitis		
Typhoid		
Tonsillitis		
Chronic Colds		
Head Injuries		
Mastoidectomy		
Asthma		
Other		

14. Describe any other operations your child has had _____

Name and address of attending physician: _____

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15. Describe any other serious illnesses your child has had _____

Name and address of attending physician: _____

Medications? _____

16. Has the child had any convulsions? _____
 Under what circumstances did they occur? _____
 Was medication prescribed? _____

17. Have the child's eyes been examined? _____ Date? _____
 By Whom? _____ Results? _____

18. Has the child's hearing ever been evaluated? _____ Date? _____

By Whom? _____

Results? _____

19. Is the child presently taking any medication? _____ For what reason? _____
Name of medication? _____

C. Family History:

Mother's Birth date: _____

Highest grade completed _____

Mother's Occupation: _____

Place of Employment _____

Father's Birth date: _____

Highest grade completed _____

Father's Occupation: _____

Place of Employment _____

Brothers and Sisters:

Name	Age	Sex	Speech, Hearing, or Medical Problems
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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List any relatives of the child closer than the second cousin who have or had a hearing loss or speech-language problem. Indicate the cause if known.

Name	Relationship	Type of Problem / Cause
_____	_____	_____
_____	_____	_____
_____	_____	_____

D. Social / Behavioral / Educational History

1. Does a child play alone or with other children?

How does the child get along with other children?

How does the child get along with adults?

2. Is the child difficult to discipline? _____

Explain: _____

3. Would you describe your child as happy or unhappy? _____

4. Is the child **unusually** quiet _____ or **unusually** active?

5. Does your child have difficulty in concentrating? _____

Difficulty sleeping? _____

6. Is there anything else about your child's behavior that concerns you? _____

7. Does your child attend preschool or child care? _____

8. Name of school or child care: _____

If child care, how long has the child been enrolled? _____

Grade: _____ Teacher: _____

Special Program: _____

What kind of grades does the child make? _____

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III. ASSOCIATED SERVICES

1. Intelligence testing _____ Date _____ Where _____
Results _____

2. Neurologic testing _____ Date _____ Where _____
Results _____

3. Physical Therapy and/or Evaluation _____ Date _____
Where _____

4. Occupational therapy and/or Evaluation _____ Date _____
Where _____

VI. PLEASE ADD ANY INFORMATION OR COMMENTS YOU THINK MIGHT BE HELPFUL. THANK YOU!!

****Adopted from:

Ehrlich, Carol H., Ph.D, "Evaluation of Young Children and the Elderly" (chapter 32), Handbook of Clinical Audiology (second edition); Edited by Jack Katz, Ph.D., The Williams and Wilkins Company, Baltimore, Maryland (1978), pp. 388-396

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