TIME TO SPROUT
SPEECH AND LANGUAGE SERVICES, LLC

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, occupational devlopment 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:

_____

CASE HISTORY for CHILDREN

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? _____

Case HISTORY for CHILDREN

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 yeswhen, 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 listresults/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

_____

Qualityof 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

_____

_____

CASE HISTORY for CHILDREN

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?

☐Bleeding ☐Virus infection ☐Swelling
☐German measles – Rubella ☐High blood pressure ☐Diabetes
☐Low blood pressure ☐Heart condition ☐Convulsions
☐Asthma ☐Excessive weight gain/loss ☐Thyroid condition
☐Toxemia ☐Kidney disease ☐Rh Negative blood
☐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?

_____

CASE HISTORY for CHILDREN

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		
Diptheria		
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: _____

_____

CASE HISTORY for CHILDREN

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
_____	____	____	_____
_____	____	____	_____
_____	____	____	_____

CASE HISTORY for CHILDREN

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? _____

CASE HISTORY for CHILDREN

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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