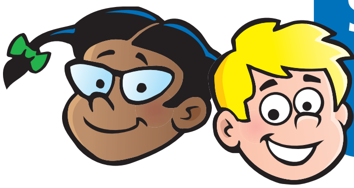

SPEECH-LANGUAGE-HEARING CASE HISTORY FORM

Identifying and Family Information:

Child's Name:________________ Birthdate:____________ Sex: ❑ M ❑ F

Father's Name:________________ Daytime Phone:________________

Address:________________ Cell Phone:________________

________________ E-mail:________________

____

Mother's Name:________________ Daytime Phone:________________

Address:________________ Cell Phone:________________

________________ E-mail:________________

____

Doctor's Name: ________________ Doctor's Phone: ________________

Child lives with (check one):

❑ Birth Parents ❑ Foster Parents ❑ One Parent

❑ Adoptive Parents ❑ Parent and Step-Parent ❑ Other ____________

Other children in the family:

Name	Age	Sex	Grade	Speech/Hearing Problems

Child's race/ethnic group:

❑ Caucasian, Non-Hispanic ❑ Hispanic ❑ African-American

❑ Native American ❑ Asian or Pacific Islander ❑ Other ____________

Is there a language other than English spoken in the home? ❑ Yes ❑ No

If yes, which one?________________

Does the child speak the language? ❑ Yes ❑ No

Does the child understand the language? ❑ Yes ❑ No

Who speaks the language? ________________

Which language does the child prefer to speak at home? ________________

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Speech-Language-Hearing

Do you feel your child has a speech problem? ❑ Yes ❑ No
If yes, please describe. ______________________________
____
____

Do you feel your child has a hearing problem? ❑ Yes ❑ No
If yes, please describe. ______________________________
____
____

Has he/she ever had a speech evaluation/screening? ❑ Yes ❑ No
If yes, where and when? ______________________________
What were you told? ______________________________
____
____

Has he/she ever had a hearing evaluation/screening? ❑ Yes ❑ No
If yes, where and when? ______________________________
What were you told? ______________________________
____
____

Has your child ever had speech therapy? ❑ Yes ❑ No
If yes, where and when? ______________________________
What was he/she working on? ______________________________
____

Has your child received any other evaluation or therapy (physical therapy, counseling, occupational therapy, vision, etc.)? ❑ Yes ❑ No
If yes, please describe.______________________________
____
____
____

Is your child aware of, or frustrated by, any speech/language difficulties?______________________________
____

What do you see as your child's most difficult problem in the home? ______________________________
____

What do you see as your child's most difficult problem in school?______________________________
____

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Birth History

Was there anything unusual about the pregnancy or birth? ❑ Yes ❑ No

If yes, please describe. ____

____

____

How old was the mother when the child was born? ______________

Was the mother sick during the pregnancy? ❑ Yes ❑ No

If yes, please describe. ____

____

How many months was the pregnancy?__________

Did the child go home with his/her mother from the hospital? ❑ Yes ❑ No

If child stayed at the hospital, please describe why and how long. ______________________

____

____

Medical History

Has your child had any of the following?

❑ adenoidectomy
❑ allergies
❑ breathing difficulties
❑ chicken pox
❑ colds
❑ ear infections
How often?__________
❑ ear tubes

❑ encephalitis
❑ flu
❑ head injury
❑ high fevers
❑ measles
❑ meningitis
❑ mumps
❑ scarlet fever

❑ seizures
❑ sinusitis
❑ sleeping difficulties
❑ thumb/finger sucking habit
❑ tonsillectomy
❑ tonsillitis
❑ vision problems

Other serious injury/surgery: ____

Is your child currently (or recently) under a physician's care? ❑ Yes ❑ No

If yes, why?____

____

Please list any medications your child takes regularly: ______________________________

____

____

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Developmental History

Please tell the approximate age your child achieved the following developmental milestones:

___________ sat alone
___________ babbled
___________ put two words together
___________ walked
___________ grasped crayon/pencil
___________ said first words
___________ spoke in short sentences
___________ toilet trained

Does your child...

- ❏ choke on food or liquids?
- ❏ currently put toys/objects in his/her mouth?
- ❏ brush his/her teeth and/or allow brushing?

Current Speech-Language-Hearing

Does your child...

- ❏ repeat sounds, words or phrases over and over?
- ❏ understand what you are saying?
- ❏ retrieve/point to common objects upon request (ball, cup, shoe)?
- ❏ follow simple directions (“Shut the door” or “Get your shoes”)?
- ❏ respond correctly to yes/no questions?
- ❏ respond correctly to who/what/where/when/why questions?

Your child currently communicates using...

- ❏ body language.
- ❏ sounds (vowels, grunting).
- ❏ words (shoe, doggy, up).
- ❏ 2 to 4 word sentences.
- ❏ sentences longer than four words.
- ❏ other ______________________________.

Behavioral Characteristics:

- ❏ cooperative
- ❏ attentive
- ❏ willing to try new activities
- ❏ plays alone for reasonable length of time
- ❏ separation difficulties
- ❏ easily frustrated/impulsive
- ❏ stubborn
- ❏ restless
- ❏ poor eye contact
- ❏ easily distracted/short attention
- ❏ destructive/aggressive
- ❏ withdrawn
- ❏ inappropriate behavior
- ❏ self-abusive behavior

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School History

If your child is in school, please answer the following:

Name of school and grade in school: ______________________________

____

Teacher's name: ______________________________

____

Has your child repeated a grade? ______________________________

____

What are your child's strengths and/or best subjects? ______________________________

____

Is your child having difficulty with any subjects? ______________________________

____

Is your child receiving help in any subjects? ______________________________

____

Additional Comments

____
____
____
____
____
____
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