

Comprehensive Language  
& Speech Services, Inc.

24044 Cinco Village Center Blvd.  
Katy, TX 77494  
713-256-6057

# Case History

## General Information

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ M / F

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Child Lives With: \_\_\_\_\_

Mother/Guardian's Name: \_\_\_\_\_

Mother/Guardian Occupation: \_\_\_\_\_

E-mail: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Father/Guardian's Name: \_\_\_\_\_

Father/Guardian Occupation: \_\_\_\_\_

E-mail: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

## Referral Information

Referred by: \_\_\_\_\_ Phone: \_\_\_\_\_

Pediatrician: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Reason for Referral: \_\_\_\_\_

\_\_\_\_\_

## Family Information

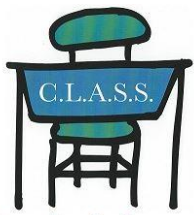
Siblings and other persons in the home (name and ages):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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### Family Information (cont'd)

Language(s) spoken in the home: \_\_\_\_\_

Primary language spoken by guardians: \_\_\_\_\_

Primary language spoken by child: \_\_\_\_\_

Other speech, language, hearing, communication, etc. problems in family:

\_\_\_\_\_

\_\_\_\_\_

### Prenatal/Birth History

Health during pregnancy (medications, complications, illnesses, etc.):

\_\_\_\_\_

\_\_\_\_\_

Gestation Length: \_\_\_\_\_ weeks Birth Weight: \_\_\_\_\_

Hospitalized after mother released? \_\_\_\_\_

Other pertinent delivery/birth information: \_\_\_\_\_

\_\_\_\_\_

**Medical History:** Check any applicable conditions:

Adenoidectomy

Headaches

Scarlet Fever

Allergies

Head Injury

Seizures

Asthma

Hearing Problems

Sinusitis

Chicken Pox

High Fever

Sleeping Difficulties

Croup

Influenza

Tinnitus

Dizziness

Measles

Tonsillectomy

Ear Infections # \_\_\_\_\_

Meningitis

Tonsillitis

Ear Tubes

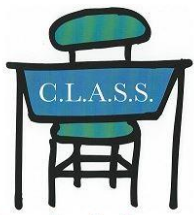
Mumps

Vision Problems

Encephalitis

Pneumonia

Other \_\_\_\_\_



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## Case History

### Communication

Describe the child's communication (gesture, single words, short phrases, sentences, etc.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

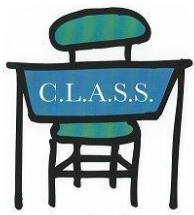
Does the child use words more than gestures? \_\_\_\_\_

Do you feel that your child has a communication problem? If so, please describe. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

When was the problem noticed and by whom? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has the problem changed/progressed? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has your child had a speech evaluation? If so, where/when and what were the results? (Please provide a copy of the evaluation if possible.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



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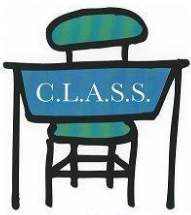
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Has your child received speech therapy? If so, where/when and what was the focus? \_\_\_\_\_

Has your child had any other evaluations? If so, please describe details and results. (Please provide a copy of the evaluation if possible.) \_\_\_\_\_

Is your child aware and/or frustrated by speech/language difficulties? Y / N  
How does the communication problem impact your child in the home?

How does the communication problem impact your child in school?



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# Case History

## Educational History

School \_\_\_\_\_ Grade \_\_\_\_\_

Teacher(s) \_\_\_\_\_

Child's academic strengths \_\_\_\_\_

\_\_\_\_\_

Child's academic weaknesses \_\_\_\_\_

\_\_\_\_\_

Areas that child is receiving assistance in school (e.g. writing, math, etc.):

\_\_\_\_\_

Does the child receive special services? If so, describe. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please describe goals addressed within the child's IEP, if applicable. (Or provide a copy of the current IEP for review.) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Other Information

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Person Completing Form \_\_\_\_\_

Relationship to client \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_