Moon Valley
Speech and Language

Case History Form

Child's Name: _____ Nickname: _____

Parent's names: _____ Address: _____

Contact information: (phone) _____ Email: _____

Primary Care Physician: _____ Referring Physician: _____

Reason for this evaluation: _____

Check all that describe your child's voice:

_____ hoarse

_____ breathy

_____ voice breaks/cracks

_____ harsh

_____ raspy

_____ frequently clears throat

_____ frequently yells/talks loudly

_____ frequently makes funny noises

_____ talks too softly

_____ talks too loudly

_____ frequently whispers

_____ deals with anger by yelling

_____ can't sing high notes

_____ complains that talking makes him/her tired

_____ voice worse in morning

_____ voice worse with use

_____ complains of tickling/choking sensation

_____ frequent burping

_____ exposed to smoke

_____ voice sounds different from peers

Check all interpersonal skills your child exhibits:

_____ talks too much

_____ aggressive behavior

_____ poor self-esteem

_____ poor listening skills

_____ doesn't take turns when talking

_____ doesn't respond to cues to change behavior

_____ always trying to get attention

_____ doesn't adapt behavior to situation

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Medical Conditions:

Does your child have now, or have a history of, any of the following? (Please provide more information on those marked *yes*.)

Yes / No Asthma _____

Yes / No Allergies _____

Yes / No Upper respiratory infections/conditions_____

Yes / No Gastroesophageal reflux(GERD)/Heartburn_____

Yes / No Hearing Loss _____

Yes / No Frequent Laryngitis _____

Yes / No Frequent Sore Throats _____

Yes / No Enlarged tonsils and adenoids _____

Has your child had any surgeries? Yes No If *yes*, please list:

_____

_____

Medications: List any medications your child takes and what the medication is for:

Medication	Purpose
_____	_____
_____	_____

Hearing acuity:

When was the last time your child's hearing was tested? _____

What were the results of that evaluation? _____

Has your child been examined by an Ear, Nose and Throat Doctor? Yes No

If yes, please list date(s) and result(s) of the examination:

_____

_____

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Diet:

How often does your child drink beverages with caffeine? (e.g. soda)?

_____ never

_____ occasionally (1-3 per week)

_____ has at least one every day

_____ has more than one every day

Extra-Curricular Activities:

What extra-curricular activities is your child involved in?

_____

_____

_____

How often does he/she participate in those activities:

_____

_____

_____

Social-emotional:

Is your child experiencing frustration surrounding communication? (please explain)

_____

Tell me about your child! (Favorite indoor and outdoor activities, preferred toys, daily routine, etc….)

_____

_____

_____

_____