Speech and Language Therapy Express
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Speech and Language Case History Form

Child's Name: _____ Birthdate: _____ Sex: __ M ___ F

Child's race/ethnic group: __ Caucasian, non Hispanic __ African American __ Hispanic
__ Asian or Pacific Islander __ Native American __ Other

Caregiver 1:
Address: _____ Daytime Phone: _____
_____ Cell Phone: _____
_____ Email: _____
Occupation: _____

Caregiver 2:
Address: _____ Daytime Phone: _____
_____ Cell Phone: _____
_____ Email: _____
Occupation: _____

Doctor's Name: _____ Doctor's Phone: _____

Child Lives With: __ Birth Parents __ Foster Parents __ One Parent
__ Adoptive Parents __ Parent and step parent __ Other

Siblings in the Household: Age Sex Grade Speech/Hearing Problems

_____
_____
_____
_____

Is English the primary language spoken in the home: __ yes __ no
If no, what language is spoken? _____
Does the child speak the language? __ yes __ no
Does the child understand the language? __ yes __ no
What language does the child prefer to speak? _____

Who referred your child for an evaluation? _____
How did you hear about Speech and Language Therapy Express? _____
_____
_____

Birth History:

Mother's Age at Birth: _____ Number of Pregnancies: _____
How many weeks gestation? ____ Birth weight: ____ pounds, ____ ounces Length: _____
Did mother receive prenatal care? __ yes __ no
Were there any illnesses or complications during pregnancy? __ yes __ no
If yes, please explain: _____
Did mother consume any of the following during pregnancy?
___ alcohol ___ cigarettes ___ recreational drugs
Type of delivery: ___ vaginal ___ cesarean
Did the infant require a stay in the neonatal intensive care unit (NICU) ___ yes ___ no
If yes, please explain: _____
_____
_____
Any injuries or deformities at birth: ___ yes ___ no
If yes, please explain: _____
_____
_____

Developmental History:

At approximately what age did your child do the following:
_____ sat independently _____ crawled _____ stood alone
_____ walked alone _____ drank from a cup _____ used a spoon
_____ toilet trained
Does your child demonstrate any difficulties with gross motor skills? __ yes __ no
__ walking __ hopping __ running __ jumping
Does your child demonstrate any difficulties with fine motor skills? __ yes __ no
__ stacking blocks __ buttoning __ cutting __ zipping

Hearing:

Did your child pass his/her newborn hearing screenings? ___ yes ___ no
Do you have any concerns regarding your child's hearing? ___ yes ___ no
If yes, please explain: _____
Is there a history of hearing loss in the family? ___ yes ___ no
Has your child had a hearing evaluation performed in the past? ___ yes ___ no
Date: _____ Results: _____
_____
_____
Does your child have a history of middle ear infections? ___ yes ___ no
Does your child have PE tubes? ___ yes ___ no
If yes, which ear(s)? __ Left __ Right Still in place? ___ yes ___ no
When was the procedure done? _____ By whom? _____
Does your child have a hearing loss? ___ yes ___ no
Does your child wear hearing aids? ___ yes ___ no
If yes, which ear(s) ___ left ___ right
Does your child wear a cochlear implant? ___ yes ___ no
If yes, when was the implant completed? _____ Where? _____

Speech and Language:

Has your child previously received: ___ a Speech/Language Evaluation ___ Speech/Language Therapy
If yes: Where: _____ When: _____ Results: _____
_____
_____

Please indicate the age in months that your child did the following:
__cooed __ babbled(i.e. dadada, mamama) __ used single words __ combined two words
Is there a family history of any of the following:
___ speech disorder ___ learning disability ___ language disorder
If yes, please explain: _____
_____
_____

Do you feel your child's communication skills have regressed? ___ yes ___ no
If yes, please explain: _____
_____

Do you have concerns regarding your child's understanding of language? ___ yes ___ no
If yes, please explain: _____
_____
_____

Would you describe your child as: ___ verbal ___ nonverbal

How does your child communicate?	__ body language/gestures	__ sounds (vowels/grunting)	__ single words
	__ 2-4 word phrases	__ sentences (more than 4 words)	__ other
Does your child:	___ repeat sounds, words or phrases over and over	__ understand what you are saying	__ point to requested objects
	__ follow simple directions (i.e. shut the door, come here)	__ respond correctly to yes/no questions	__respond correctly to "wh" questions

Does your child demonstrate frustration when trying to communicate? __ yes ___ no
If yes, please describe behaviors: _____
_____
_____

How often do family members understand your child's speech? __ never __ sometimes __ most of the time __ always
How often do others understand your child's speech? __ never __ sometimes __ most of the time __ always
Does your child make any sounds incorrectly? __ yes __ no
If yes, please explain: _____
_____
Please describe any concerns you have regarding your child's speech and/or language: _____
_____
_____
_____

Feeding:

Does your child have difficulty with chewing/swallowing? ___ yes ____ no
Does your child avoid any foods or consistencies (pureed, soft, crunchy, chewy, hot, cold)? ___ yes ____ no
If yes, please describe: _____
_____
Does your child mouth objects (i.e. hand, toys, pencils, crayons, etc.)? ___ yes ____ no
Does your child frequently gag while eating? ___ yes ____ no

Behavior Characteristics:

Do you have concerns regarding your child's behavior? __ yes __ no

Would you describe your child as (check all that apply):

__ cooperative	__ restless	__ attentive	__ easily distracted/short attention
__ poor eye contact	__ willing to try new things	__ plays independently for a reasonable time	__ destructive/aggressive
__ separation difficulties	__ withdrawn	__ easily frustrated/impulsive	__ inappropriate behavior
__ stubborn	__ self-abusive	__ enjoys playing with others	__ repetitive behaviors

Medical History:

Please describe any diagnoses your child has received from a medical professional (i.e. autism, cerebral palsy, developmental delay, seizures, etc.)? _____

_____

Please list any medications your child is taking and what the medication treats: _____

_____

Has your child been hospitalized for illness? __ yes __ no

If yes, when: _____ Why: _____

_____+_____

_____+_____

Has your child had any surgeries? ___ yes ___ no

If yes, please describe: _____

Does your child have any allergies? ____ yes ____ no

If yes, please describe: _____

Educational History (Please complete if your child attends a daycare or school setting):

Name of school: _____ Grade: _____

Has your child ever repeated a grade? ___ yes ___ no

Does your child demonstrate academic difficulties? ___ yes ___ no

Please describe strengths and weaknesses: _____

_____

_____

Has your child been evaluated in the school setting? __ yes ___ no

What were the results of the evaluation? _____

_____

Please describe any special education services your child receives in the school setting: _____

_____

_____

Form completed by: _____ Date: _____

Relationship to child: _____