Speech & Language Stimulation Center, Inc.
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Speech & Language Stimulation Center

Case History Form – Child

(The information supplied on this form will be confidential. It will help us to appropriately prepare for our evaluation. We can also discuss any information at the time of the appointment. Usually testing takes about an hour and we like to discuss our impressions with you or demonstrate some things to you for 15-30 min thereafter.) ******please fill out each line or put n/a if not relevant******

Name of Child: _____Today's date: _____
Date of Birth: _____ Age: _____Present grade level:_____
School (please specify preschool, school, or homeschool):_____
Does child receive support services, an IFSP or an IEP (at school)?_____

	Name	*Age (Optional)*	*Occupation*
Father:			
Mother:			
Guardian or co-parent:			

(Please indicate who is filling out form) _____
If either parent lives away from the child, please indicate:
_____

Other Children in Family:

Name:	*Age:*	*Gender:*	*Any language/speech difficulties:*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Is there any family history of stuttering, attention problems, learning problems, or a delay of speech-language skills? Please explain _____

Child's Physician(s): _____
Who referred you to our practice?_____ Why were you referred?
_____
A copy of your child's initial evaluation report will be sent to the child's referring physician; is this ok?_____
Do you want a report sent to anyone else? To whom? (A release of info needs to be signed)
_____
Does your child have a medical diagnosis? (list all)
_____

Is your child currently or has your child previously received therapy services that you would like us to know about? (early intervention, occupational, physical, vision, speech, music therapy,counseling)_____

_____

MATERNAL/BIRTH HISTORY

Was this child adopted? _____At what age?_____What was the native language spoken?_____

Were there any medications taken or medical complications during the pregnancy?

_____

Was there any alcohol or drug use during the pregnancy?

_____

Was the child full term? _____ If premature, by how many weeks? _____

Briefly describe the delivery _____

Child's weight at birth: _____ Describe any birth injuries/complications?

_____

Were any special treatments or medications given to the child at birth or in the following days/weeks? _____

Has any genetic testing been done? (If yes, please describe)_____

Did your child have any feeding or swallowing problems as an infant/toddler? _____

Describe _____

Did your child use a pacifier? _____ Did he/she suck his/her thumb?_____

Until what age?_____

DEVELOPMENTAL MILESTONES (fill out as much as you can)

At what age did the following occur:

crawled _____ sat_____ walked_____ began self-feeding_____

drank from a cup_____ first words _____ combined words into simple sentences _____

Did your child make babbling or cooing sounds during the first six months of life?

_____

Once your child started to talk did he/she keep adding new words?

_____

MEDICAL HISTORY

Is your child currently healthy?_____

Describe any illnesses/ accidents/ hospitalizations of your child? (Include the age)

_____

_____

_____

Does your child have a history of ear infections/ PE tubes placed? Please be specific.

_____

_____

_____

Has your child ever had seizure activity?_____

Is your child currently receiving any medical treatment or on medication?

_____

Does your child have any allergies/asthma?

_____

Sometimes there is a therapy dog in the office – would this be a problem?_____

Has your child's hearing been tested?_____ By whom and when?_____

Has your child's vision been tested?_____ by whom and when?_____

Results of hearing/vision tests:_____

Describe any visual impairments, corrections, vision therapy, etc. _____

_____

PRESENT CONCERN

Describe in your own words your concerns regarding your child's speech/language, reading/writing, learning or hearing? _____

_____

_____

_____

_____

When was the problem first noticed?

_____

What games/activities/toys does your child prefer?

_____

_____

Please give examples of how your child communicates at the present? (e.g., points, grunts, whines, gestures, talks in sentences, etc.): _____

_____

_____

_____

Does your child make any sounds incorrectly? _____, if so, which ones? _____

_____

_____

Describe any recent changes in your child's speech or language development?

_____

_____

_____

Does your child understand what you are saying to him/her? (conversations, sentences, etc.)

_____

Can he/she follow simple commands/directions, even outside of typical routines?

_____

Does your child have difficulty concentrating?_____ If yes, under what conditions?

_____

Does your child enjoy playing with other children?_____ Give examples if you have a concern

_____

Does he/she prefer to play alone?

_____

Is your child overly sensitive to touch (especially around the face), lights, smells or sounds?

_____

Please describe any other concerns you have: _____

_____

_____

What are your child's strengths? _____

_____

How would you describe your child's personality? _____

_____

_____

What would be your primary goals for us to keep in mind? _____

_____

_____

Do you have any additional information you would like us to know?_____

_____

_____

_____