Case History Form

The information provided below will help Speech Matters evaluate and treat your child's communication and learning needs. All information provided is confidential.

Part 1: Demographic Information

Child's Name: _____ Date of Birth: _____ M___F___

Nickname: _____

Address: _____

Parent/Guardian 1: _____ Parent/Guardian 2: _____

Email: _____ Email: _____

Cell: _____ Cell: _____

Emergency Contact Name _____ Emergency Contact Phone #_____

Note: Please List names and contact information of individuals who may bring your child to therapy:

Name of Alternate Caregiver	Alternate Caregiver Phone Number	Relationship to child (grandparent, nanny, friend, etc.)

Child lives with:

☐ Birth parents ☐ Foster parents ☐ One parent
☐ Adoptive parents ☐ Parent & Step-Parent ☐ Other _____

Pediatrician: _____
Name Town and Practice Name Phone

Referred By (Who's idea was it to seek out speech and language services?):

_____

Part 2: Family History

Parent History	Parent 1	Parent 2
Name		
Age		
Occupation		
Highest Grade Completed		
Language /Learning Problems (Specify)		
Medical Problems (Specify)		

Other children in the family:

Name	Age	Sex	Grade	Language /Learning Problems (Specify)

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 at home? _____

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

Areas of concern/reason for evaluation and/or treatment:

_____

_____

_____

Part 3: Birth Information

Age of biological mother at birth: _____ Length of Pregnancy:

_____

Were there any complications during pregnancy or at birth? ☐ Yes ☐ No

If yes, describe (illnesses, accidents, medications, etc.):

_____

_____

Weight at Birth: _____

Did your child require an extended stay in the hospital due to complications? ☐ Yes ☐ No
If Yes, please explain:

_____

Is your child biological or adopted? _____
If adopted, please provide adoption information (date, location, important information)

Part 4: Developmental History

Oral Motor Skills

Has your child experienced any of the following?

Chewing difficulties ☐ Yes ☐ No

Excessive drooling ☐ Yes ☐ No

Thumb sucking ☐ Yes ☐ No If yes, how long? _____

Pacifier use ☐ Yes ☐ No If yes, how long? _____

Difficulty tolerating specific food textures ☐ Yes ☐ No If yes, explain_____

What does your child primarily drink from? (e.g. cup, straw, sippy cup, bottle) _____

Early Developmental Milestones

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

Babbled _____ Sat alone _____

Said First Words _____ Walked _____

Put two words together _____ Grasped Crayons/Pencils _____

Spoke in short sentences _____ Toilet Trained _____

Please list at what age your child had or date s/he was diagnosed with any of the following conditions/procedures (if applicable):

☐ Adenoidectomy_____ ☐ Flu_____ ☐ Rubella _____

☐ Breathing difficulties_____ ☐ Headaches _____ ☐ Seizures _____

☐ Chicken Pox _____ ☐ Head Injury _____ ☐ Sinusitis _____

☐ Frequent / Constant Colds ____ ☐ High Fevers _____ ☐ Tonsillectomy _____

☐ Ear Infections ☐ Measles _____ ☐ Meningitis _____

How often? _____ ☐ Encephalitis _____ ☐ Tonsillitis _____

☐ Ear Tubes ☐ Mumps _____ ☐ Vision Problems _____

Date _____ ☐ Executive Function Difficulties _____

☐ ADD/ADHD _____ ☐ Autism Spectrum Disorder/Asperger's Syndrome _____

Has your child had a recent hearing evaluation/screening? ☐ Yes, results_____ ☐ No

Does your child have any allergies? ☐ Yes, to what_____ ☐ No

Please list any medications your child takes regularly _____

Is your child up to date on their vaccines? ☐ Yes ☐ No

Pease list any other medical difficulties, developmental concerns, major accidents, or hospitalizations:

_____

_____

_____

Part 5: Communication History / Status

Please complete **one** area in Part 5, **either Section A or B**, whichever best pertains to your child.

A. Emerging and Early Language Development:

Your child currently communicates using (check all that apply):

- ☐ body language (pointing, gestures, signs)
- ☐ sounds (vowels, consonants, grunting)
- ☐ single words (shoe, doggy, up)
- ☐ 2 to 4-word phrases. (ball up, me go)
- ☐ sentences longer than 4 words
- ☐ AAC System/ Augmentative and Alternative Communication

Does your child:

Repeat sounds, words or phrases over and over?	☐ Yes	☐ No
Initiate interaction with others to get needs met or to play?	☐ Yes	☐ No
Take turns in games (e.g. roll a ball back/forth, take turns stacking blocks)?	☐ Yes	☐ No
Makes eye contact with you, and follows your point and gaze?	☐ Yes	☐ No
Understand what you are saying?	☐ Yes	☐ No
Retrieve/point to common objects upon request (ball, cup, shoe)?	☐ Yes	☐ No
Follow simple commands (“shut the door” or “get your shoes”)?	☐ Yes	☐ No
Respond correctly to yes/no questions?	☐ Yes	☐ No
Respond correctly to who/what/where/when/why questions?	☐ Yes	☐ No

Other/Comments about your child’s current speech and language skills:

_____

_____

B. Later Language Development:

Does your child:

Understand stories read aloud or spoken to him/her?	☐ Yes	☐ No
Answer fact-based, literal questions about everyday events and stories?	☐ Yes	☐ No

Answer inferential questions about everyday events and stories?	☐ Yes	☐ No
Understand and use figurative language and sarcasm?	☐ Yes	☐ No
Understand and interpret body language and environmental cues appropriately	☐ Yes	☐ No
Formulate language effectively to share ideas and tell stories?	☐ Yes	☐ No
Easily follow multi-step instructions in school and at home?	☐ Yes	☐ No
Have difficulty with word finding or retrieval?	☐ Yes	☐ No
Experience disfluencies/stutters in his/her speech?	☐ Yes	☐ No
Have difficulty with reading comprehension?	☐ Yes	☐ No
Have difficulty writing?	☐ Yes	☐ No

Other/Comments about your child's current speech and language skills:

_____

_____

Part 6: Social & Behavioral Characteristics

Does your child experience any of the following? Check all that apply/describe your child:

☐ cooperative	☐ has trouble sitting still
☐ poor eye contact	☐ inappropriate behaviors
☐ willing to try new activities	☐ easily distracted/short attention
☐ separation difficulties	☐ destructive/aggressive
☐ easily frustrated/impulsive	☐ flexible with change and changes in routine
☐ strong willed	☐ transitions easily
☐ plays well with peers	☐ sensitive to sound, touch and/or textiles

Does your child make friends easily?	☐ Yes	☐ No
Does your child have more success interacting with adults than peers?	☐ Yes	☐ No
Do you have any concerns about your child's social skills or ability to make/keep friends?	☐ Yes	☐ No

If yes, please describe:

_____

_____

What toys/activities/interests does your child enjoy?

_____

_____

Is your child aware of any difficulties s/he may be having?	☐ Yes	☐ No

If yes, how does s/he feel about it?

_____

_____

Part 7: School/Program History

Please provide the following information related to your child's daycare/school program:

School/Organization Name: _____ City: _____

State:_____

Current Grade in school, if applicable: _____

If daycare, how many days/week, full/half days? _____

Has his/her teacher reported any concerns to you? ☐ Yes ☐ No
If yes, please describe:

_____
_____

Have you reported any concerns to the teacher? ☐ Yes ☐ No
If yes, please describe.

_____
_____

How is your child doing academically (or pre-academically)? Please comment on reading and written language.

_____
_____

Does your child like school? ☐ Yes ☐ No
Does your child enjoy reading? ☐ Yes ☐ No
Does your child enjoy being read to? ☐ Yes ☐ No

Part 8: Additional Services and Therapeutic Intervention

Is your child on an Individualized Family Service Plan (IFSP) through Early Intervention (EI) ☐ Yes ☐ No

*If so, please provide a copy for our records in order to coordinate care for your child.

Is your child on an Individualized Educational Program (IEP) at school? ☐ Yes ☐ No

*If so, please provide a copy for our records in order to coordinate care for your child.

Is your child receiving any other interventions or therapies outside of school or EI? If yes, please list the following:

Type of Service	Frequency/Duration of Sessions	Name of Center/Clinic	Provider Name	Provider Contact Information (phone and/or email)

Please list any previous evaluations/testing your child has completed (i.e. speech/language; neurological; psychological, central auditory processing, occupational therapy, physical therapy, ABA etc.):

Type of Evaluation/Testing	Date(s) of Evaluation/Testing	Name of Center/Clinic	Provider Name	Provider Contact Information (phone and/or email)

_____ _____

Parent/Guarantor Signature Date

_____ _____

Parent/Guarantor Name (Printed) Client Name (Printed)