SPEECH-LANGUAGE-HEARING CASE HISTORY FORM

Identifying and Family Information:

Child's Name: ______________________ Birthdate: ______________________

Father's Name: ______________________ Phone #: ______________________

Mother's Name: ______________________ Phone #: ______________________

Email: ____

Child lives with (check one):

☐Birth Parents ☐Foster Parents ☐One Parent

☐Adoptive Parents ☐Parent and Step-Parent ☐Other ____________

Other children in the family:

Name	Age	Sex	Grade	Speech/Hearing Problems

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? ______________________

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

What is your main concern regarding your child's speech and language development?

____

____

Is there a history of speech and language difficulties in your family?

☐Yes ☐No If yes, please list relationship and difficulty.

____

Pregnancy & Delivery (length of pregnancy, complications, hospitalizations)

cesarean section: yes no Birth weight: ____________ Length: ____________

____

____

Medical History

Has your child had any of the following?

- ☐ Adenoidectomy
- ☐ Tonsillectomy
- ☐ Tonsillitis
- ☐ Ear infections
  - How often? ____________________
  - Treatment used: ________________
- ☐ Hearing loss
- ☐ Ear tubes
- ☐ Allergies
- ☐ Breathing difficulties
- ☐ Head injury
- ☐ Seizures
- ☐ Sleeping difficulties
- ☐ Thumb/finger sucking
- ☐ Vision problems
- ☐ Other_________

Comments:____

____

Has your child had his/her hearing tested? ☐Yes ☐No
Date of Audiological Examination: ____________________
Where: ____ Dr: ______________________________
Results: _______________________________________ Recommendations: ________________
____

Please list any medications your child takes regularly:____
____

Has your child received Early Intervention services? ☐Yes ☐No
When did services begin? Month: _______________ Year: _____________

What type(s) of services? **Please circle ALL that apply.**

Speech/Language Therapy   Occupational Therapy   Physical Therapy

Developmental Teacher   Behavioral Therapy

What is/was the frequency of services: ____

SPEECH Goals/Objectives targeted: ____

____

Has your child received private speech and language therapy? ☐Yes ☐No
When did services begin? Month: ____________ Year: ________________
Where: ______________________________ Therapist: ______________
Goals/Objectives targeted: ____

Does your child currently attend a preschool program or daycare? ☐Yes ☐No
Where: ______________________________ Hours per day:______________
Days per week: 1 2 3 4 5 full day half day

Developmental History

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

__________Babbled __________Put two words together
__________Said first words: __________ __________Spoke in short sentences

Does your child...

☐ choke on food or liquids?

☐ currently put toys/objects in his/her mouth?

☐ brush his/her teeth and/or allow brushing?

Current Speech-Language-Hearing

Does your child...

☐ repeat sounds, words, or phrases over and over?

☐ understand what you are saying?

☐ follow simple directions ("Shut the door" or "Get your shoes")?

☐ respond correctly to yes/no questions?

☐ respond correctly to who/what/where/when/why questions?

Your child currently communicates by...

☐ gestures.

☐ sounds (vowels, grunting)

☐ words (shoe, doggy, up)

☐ 2 to 3 word phrases

☐ sentences longer than 3 words

☐ other

Articulation Skills:
What percentage of the time do you understand your child? ___________

What percentage of the time do unfamiliar communication partners understand your child?___________

What are your articulation concerns for your child? (please list sounds that you notice are problematic)_
____

Does your child become frustrated when he/she cannot be understood? ________________________

How does he/she handle the frustration? ____
____

Feeding and Oral Motor Skills:
Does your child prefer certain foods over others? □Yes □No
If yes, please explain:____

Does your child prefer certain textures of food over others? □Yes □No
If yes, please explain:____

Does your child utilize the following: bottle sippy cup open cup straw

How does your child feed himself/herself? finger feeds utensils

Does your child blow kisses? □Yes □No

Does your child blow bubbles? □Yes □No

Additional Comments

Please list some of your child's likes and dislikes.
____
____
____
____

If there is anything else I need to know about your child, please list below.
____
____
____
____