FAMILY SPEECH & THERAPY SERVICES

Child Case History

Please complete the following information about your child to assist the therapist in evaluating your child. If a question does not apply to your child please mark "N/A".

Date:_____

Child Name:_____ DOB:_____

This form was completed by:

- ❑ Mother
- ❑ Father
- ❑ Guardian
- ❑ Other: _____

Describe your concerns regarding your child:

_____

_____

_____

_____

When did you first notice a problem?

_____

Describe your goals for your child

_____

_____

Birth History:

Did mother or child experience any of the following?

- ❑ Illness/injury before birth
- ❑ Bed rest
- ❑ Premature by _____ weeks
- ❑ Meconium aspiration
- ❑ Breech delivery
- ❑ Caesarean Delivery
- ❑ Need for oxygen or respiratory assistance
- ❑ Jaundice
- ❑ Feeding difficulties following birth
- ❑ Unusually long hospital stay following birth
- ❑ Complications with labor and/or delivery

Please explain any checked boxes:

_____

_____

_____

Medical History:

Please check any medical diagnoses your child has:

- ❑ Autism Spectrum Disorder (diagnosed by a doctor)
- ❑ Attention Deficit Disorder
- ❑ Asperger's Syndrome
- ❑ Intellectual Disability
- ❑ Cerebral Palsy
- ❑ Down Syndrome
- ❑ Autism Spectrum Disorder (diagnosed by school)
- ❑ Attention Deficit Hyperactive Disorder
- ❑ Genetic Syndrome
- ❑ Other Chromosomal Abnormalities
- ❑ Deaf/Hearing Loss
- ❑ Cleft lip/palate

Other medical diagnoses:

_____

Has your child experienced any of the following?

- ❑ Heart Condition
- ❑ Vision problems
- ❑ Seizures
- ❑ Feeding tube
- ❑ Constipation/Diarrhea
- ❑ Tonsils/adenoids removed
- ❑ Head injury/concussion
- ❑ Difficulties sleeping
- ❑ Choking/gagging on foods
- ❑ Aspirates on foods
- ❑ Asthma
- ❑ Snoring/breathing through mouth
- ❑ Balance problems
- ❑ Tongue tie
- ❑ Thumb/finger sucking
- ❑ Sinus problems
- ❑ Frequent colds/flu
- ❑ Frequent laryngitis
- ❑ Vocal nodules/polyps

Please explain:

_____

_____

Has your child had any hospitalizations or surgeries?

- ❑ Yes
- ❑ No

Please explain:_____

_____

Please list any allergies or dietary restrictions your child has:

_____

_____

Please list any current medications your child is taking and why:

_____

_____

Hearing & Vision History

When was your child's last hearing assessment? Date:_____

Results:_____

Does your child get frequent ear infections?

- ❑ right ear
- ❑ left ear
- ❑ both

Were Ears Tubes ever placed?

- ❑ Yes
- ❑ No

When:_____ Are they still in?_____

Does your child have a hearing loss or other problems with hearing?

- ❑ Yes
- ❑ No

If yes, explain:_____

When was your child's last vision assessment?
Date:_____

Results:_____

Developmental History:

How old was your child when they:	Age	How old was your child when they:	Age
First babbled (ex. bababa)		Rolled over	
Used their first word		Sat unassisted	
Combined words		Crawled	
Drank from an open cup		Walked	
Ate table food		Potty trained	
Used silverware to feed self		Dressed Self	

Please list any other concerns related to self cares/daily tasks (ex. toothbrushing):

_____

_____

Behavior/Developmental characteristics:

- ❑ cooperative
- ❑ attentive
- ❑ willing to try new activities
- ❑ separation difficulties
- ❑ easily frustrated/impulsive
- ❑ poor eye contact
- ❑ easily distracted/short attention
- ❑ fidgets/difficulty sitting still
- ❑ destructive/aggressive
- ❑ unaware of others in the room

Speech-Language Skills

My child communicates in the following ways:

- ❑ crying
- ❑ pointing with finger
- ❑ pulling/directing other to item
- ❑ sounds (vowels/grunting)
- ❑ single Words
- ❑ 2-4 word sentences
- ❑ full sentences
- ❑ sign language
- ❑ picture communication boards
- ❑ communication device

Estimate how many words your child uses consistently: _____

Estimate the length (# of words) of your child's utterances (single words, phrases, sentences etc.):

_____

My child demonstrates difficulties with the following language/social skills:

- ❑ using full sentences
- ❑ telling a story
- ❑ asking/answering questions
- ❑ frequently repeats words/phrases heard (echolalia)
- ❑ following verbal directions
- ❑ staying on topic
- ❑ initiating a conversation
- ❑ playing/taking turns with friend

Speech Sound Production

Are there certain sounds that you've noticed your child has difficulty saying:

- ❑ Yes
- ❑ No

Please list: _____

Does your child frequently leave off the end or beginning sounds of words:

- ❑ Yes
- ❑ No

What percentage (approximately) of what your child says, do you understand? _____
What percentage do grandparents understand? _____ Unfamiliar people? _____

My child demonstrates the following reaction(s) to their speech differences:

- ❑ Is easily frustrated when not understood
- ❑ Does not seem aware of speech/communication problem
- ❑ Tries to say sounds or words more clearly when asked.
- ❑ Will attempt to use an alternative form to communicate if the original method fails

Voice and Fluency

My child demonstrates the following concerns with speech fluency and/or voice:

- ❑ Frequently stutters or repeats sounds in words
- ❑ Voice quality (harsh, hoarse, nasal voice)
- ❑ Frequent screaming
- ❑ Excessively loud talker

Educational History

My child is currently:

- ❑ In daycare at _____ How often? _____
- ❑ In preschool at _____ How often? _____
- ❑ In school at _____ Grade? _____
- ❑ Homeschooled _____ Grade? _____

Does your child receive speech or occupational therapy services through the school?

- ❑ Yes
- ❑ No

If yes, how often (ex. 2x/week speech for 20 minutes)?_____

Name of child's therapist(s):

_____

My child receives the following support service(s) at school

- ❑ Special education
- ❑ Resource room
- ❑ Adaptive physical education
- ❑ Physical therapy
- ❑ Social/emotional support
- ❑ Other:_____

Any other concerns relating to your child's academic skills?

_____

_____

Treatment History

Has your child had previous treatment or evaluation by a speech or occupational therapist?

- ❑ Yes
- ❑ No

If yes, by whom? _____

What were the results?_____

Does your child receive any other therapy?

- ❑ Yes
- ❑ No

If yes, what kind and how often?_____

Is your child followed by any other medical professional?

- ❑ Yes
- ❑ No

If yes, by whom? _____

Family History

Please list people who reside within the home and ages of siblings:_____

_____

Does anyone in your family have any language or learning difficulties?

- ❑ Yes
- ❑ No

If yes, please describe._____

_____

What is the primary language spoken in the home?_____

Are there any other languages the child is exposed to? _____

If English is a second language for your child, at what age was your child exposed to/begin to speak English?

_____

Are there any changes in family circumstances you feel we should know about? (e.g, new baby, divorce, separation, recent death in the family): _____

_____

Our therapists enjoy celebrating holidays during treatment sessions. We value each family's individual and cultural beliefs and therefore, we ask that you please check the holidays that your family celebrates. If there are holidays that are not listed, please add them to the list.

- ❑ Valentine's Day
- ❑ Christmas
- ❑ Father's Day
- ❑ St. Patrick's Day
- ❑ Hanukkah
- ❑ Thanksgiving
- ❑ Halloween
- ❑ Easter
- ❑ Mother's Day
- ❑ Fourth of July
- ❑ Ramadan

Are there any other holidays or cultural traditions you would like us to know about?

_____

_____

Please list any questions or concerns you would like to discuss at your initial treatment session:

1._____

2._____

3. _____