In Plain English, llc

Child Case History Form

Please fill out this form as completely as possible. If you need more space, attach another page, or write on the back. Call 804 539 8843 if you have additional questions regarding these forms.

Person Filling Out Form ____ Relationship to Child ____ Today's Date ____

General Information

Name ____ Birthdate ____ Age ____ Gender ____

Home Phone ____ Cell Phone ____ Email Address ____

Home Address ____

City, State, Zip ____

Mother's Name ____ Mother's Cell Phone ____

Mother's Email Address ____ Mother's Work Phone ____

Father's Name ____ Father's Cell Phone ____

Father's Email Address ____ Father's Work Phone ____

Preferred Method for Contact ____

History of Problem

Describe present problem: ____

When was the Problem first noticed? ____

By whom? ____

What do you think may have caused the problem? ____

Is your child aware of the problem? ☐ Y ☐ N

If yes, how does he or she feel about it? ____

How well is your child understood by:

☐ Mom
☐ Dad
☐ Younger Siblings
☐ Older Siblings
☐ Other Children
☐ Extended Family
☐ Unfamiliar Adults
☐ Familiar Adults

Has your child been seen by any other speech-language specialists? ☐ Y ☐ N

If yes, name of specialist: ______________________________

If yes, what were their conclusions and/or recommendations? ______________________________

____

Previous therapy? ☐ Y ☐ N   If yes, where? ______________________________

Has your child been seen by any other specialists? ☐ Y ☐ N

If yes, what were their conclusions and/or recommendations? ______________________________

____

Siblings

Name	Age	Name	Age

Primary language spoken by the child: ______________________________

With whom does the child spend most of his or her time? ______________________________

Is there a history of speech, language or hearing problems in your family? ☐ Y ☐ N

If yes, please describe: ______________________________

Health History

Length of Pregnancy	Length of Labor	Birth Weight	General Condition at Birth

Mother's general health during pregnancy (illness, accidents, medications, etc.): ______________________________

____

____

Any unusual conditions during pregnancy or delivery? ☐ Y ☐ N

If yes, please describe: ______________________________

____

Final Apgar Score: ______________________________

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Please mark if and at what age your child has had any of the following:

☐ Seizures	☐ Ear Infections	☐ Asthma
☐ Hearing Difficulties	☐ Allergies	☐ Measles
☐ Pneumonia	☐ Whooping Cough	☐ Vision Problems
☐ Diabetes	☐ Sinusitis	☐ Encephalitis
☐ High Fevers	☐ Mumps	☐ Tonsillitis
☐ Rheumatic Fever	☐ Meningitis	☐ Heart Problems
☐ Chicken Pox	☐ Dental Problems	☐ Psychological Problems
☐ Jaundice	☐ Other:	

Please explain any checked items here: ______________________________

____

Describe any major accidents or hospitalizations: ______________________________

____

Is your child taking any medications? ☐ Y ☐ N

If yes, Current Medications	Dosage	Physician
______	______	______
______	______	______
______	______	______
______	______	______

Developmental History

Age when child (approximate if necessary):

Sat Up ______ Toilet Trained ______ Dressed Self ______

Crawled ______ Fed Self ______ Tied Shoes ______

Walked ______

Dominant Hand: ☐ Left ☐ Right

Attention Span for Self-Directed Activities: ______________________________

Attention Span for Adult-Directed Activities: ______________________________

Eating and Sleeping Patterns: ______________________________

Language Development

Age when child (approximate if necessary):

Spoke First Word ______ Combined Two Words ______

Named Simple Objects ______ Used Simple Questions ______

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Does your child have any difficulty understanding you? ☐ Y ☐ N

If yes, please describe: ______

Does your child have difficulty following directions? ☐ Y ☐ N

If yes, please describe: ______

Social Development

Has your child attended day care? ☐ Y ☐ N

Activities shared with parents and siblings: ______

Favorite Places: ______

Favorite People: ______

Favorite Toys: ______

Favorite Snacks: ______

Favorite Activities: ______

Favorite TV Programs: ______

How does your child interact with others? ______

How does your child handle frustration? ______

What motivates your child most? ______

What discipline methods work best? ______

Educational History

Schools attended

______

______

Current Grade and Teacher: ______

How does your child's teacher describe his/her performance? ______

Does your child receive any special services at school or elsewhere? ______

Please provide any additional information that you feel may be helpful in the evaluation or remediation of your child: ______

______

Mail To:
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Email To:
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Please include relevant reports and information from other agencies.