



Speech & Language Therapy and Rehabilitation Specialists, LLC

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CASE HISTORY

Child's name _____ Birth Date _____ Boy ___ Girl ___
Child's address _____ City, Zip _____ Phone _____
Your name _____ Cell _____ Today's date _____

FAMILY INFORMATION

Father's name _____ Address _____
Age _____ Occupation _____ Work Phone _____ Education _____
Mother's name _____ Address _____
Age _____ Occupation _____ Work Phone _____ Education _____
Child's parents are: ___ married ___ separated ___ divorced
 ___ never married ___ father deceased ___ mother deceased
Child lives with: ___ birth mother ___ stepmother ___ foster parent(s)
 ___ birth father ___ stepfather ___ adoptive parent(s)
 ___ grandparents ___ other

Who is the child's legal guardian? _____

PEOPLE LIVING IN HOME

First and last name	Relationship to child	Gender (M or F)	Birth Date	Grade in school

How often does the child see any parent who is not in the home? _____
If adopted or foster child, when did he/she enter the home? _____
Have there been any separations between parent and this child? ___yes ___no
If yes, please explain _____
Who takes care of this child during the day? _____



Languages spoken in the home _____
 Child's primary language _____
 Child's proficiency in English: _____ Other language(s): _____
 Other modes of communication: (i.e. gestures, signing, unstructured sounds, augmentative communication device) _____

PREVIOUS TESTING:

Area tested?	Who did the testing?	When?	Results:

Has your child ever been given a medical diagnosis such as *(Please check all items that apply)**:
 Attention Deficit Disorder (ADD) Attention Deficit Hyperactivity Disorder (ADHD)
 Autism Pervasive Developmental Delay (PDD) Cerebral Palsy
 any Syndrome Hearing Loss Developmental Delay Other

Has anyone in the child's family ever *(Please check all items that apply)**:
 had speech/language therapy attended special education classes
 received counseling been diagnosed as ADD or hyperactive
 had nonfluency or stuttering difficulties had a mental health diagnosis
 had a medical diagnosis

* If you checked any item above, please explain: _____

PREGNANCY/BIRTH

Did the birth mother have any of the following conditions during this pregnancy?

	Yes	No		Yes	No		Yes	No
Prenatal care	___	___	Major Illness	___	___	breech delivery	___	___
Bleeding/spotting	___	___	Emotional stress	___	___	forceps delivery	___	___
Tobacco use	___	___	Accidents	___	___	cesarean delivery	___	___
Toxemia	___	___	Diabetes	___	___	Placenta previa	___	___
Medications	___	___	drug or alcohol use	___	___	multiple births	___	___
			induced labor	___	___			

Length of pregnancy _____ Length of Labor _____ Birth Weight _____
 Age of mother at delivery _____ length of baby _____
 Did labor and delivery go well? ___ Yes ___ No If no, please describe (i.e. meconium, labor stopped, umbilical cord, etc.) _____

Where was the child born? _____ Length of hospital stay _____



After birth, did the child...?

- have difficulty breathing
- turn blue
- have jaundice
- seem floppy
- have bruises/head injuries
- have convulsions/seizures
- have transfusions
- need oxygen
- have sucking or swallowing difficulty
- need to be transferred to another hospital
- need to be resuscitated
- other

Describe any special medical attention needed by mother and/or child following birth: _____

HEALTH HISTORY

Has your child ever had...? (Please check all items that apply)*:

- Ear infections
- Allergies
- Strep throat
- Serious illness
- serious accident
- tube feeding
- hospitalization
- frequent colds
- asthma
- seizures
- stitches
- surgery
- assistive equipment

Please explain: _____

Current Medications: _____

Child's Doctor: _____

Does your child...?

- have trouble seeing
- wear glasses
- have eyes that turn in or out
- frequently squint
- ever had eye surgery
- have trouble hearing
- wear hearing aides
- have tubes or ever had tubes

SPEECH AND LANGUAGE SKILLS

As best you can remember, when did your child...?

Say first words _____

Say short phrases _____

Say sentences _____

Does your child...?

	Yes	No	Details:
Carry on a conversation	___	___	_____
Speak less than expected for his/her age	___	___	_____
Stutter	___	___	_____
Answer questions	___	___	_____
Use sign or picture system	___	___	_____
Have speech that is unclear to other people	___	___	_____
Get frustrated when not understood	___	___	_____
Need directions repeated a lot	___	___	_____
Drool	___	___	_____



	<i>Yes</i>	<i>No</i>	<i>Details:</i>
Speak too quickly or too slowly	___	___	_____
Speak loud enough to be understood	___	___	_____
Have a hoarse/rough voice	___	___	_____
Does/did your child suck his/her thumb	___	___	If so, for how long? _____
Does/did your child use a pacifier	___	___	If so, for how long? _____

Caregiver's description of speech/language problem: _____

When was the problem first noted: _____ Who was first concerned? _____

Has any change occurred since then? _____

To what do you attribute this change? _____

EDUCATIONAL HISTORY

Name of current school _____ Current grade _____

Teacher's name _____ Does your child enjoy school? _____

Does your child demonstrate difficulty in any specific subjects? _____

Which, if any, support services does your child receive at school? _____

BEHAVIOR AND SOCIAL SKILLS:

Using a few words, please describe your child. What kind of child is he/she? _____

How does your child like to spend his/her time? _____

What activities, toys, games, TV shows and videos does he/she like best? _____

<i>Does your child...?</i>	<i>Yes</i>	<i>No</i>
always seem "on the go"	___	___
seem easily distracted	___	___
lack energy or often seem tired	___	___
usually finish what he she starts	___	___
listen to a short story for 5 minutes	___	___
Play well alone	___	___
Take turns	___	___
Stay with activity for 5-10 minutes	___	___
Separate easily from caregiver	___	___
Play well with others	___	___
Include others in his/her play	___	___
Usually get along with siblings	___	___



Are there any concerns with your child's behavior? ___ yes ___ no If yes, please describe _____

Does your child demonstrate any unusual behaviors, such as head banging, rocking, breath holding, biting, etc.? _____

What do you do when your child misbehaves? _____

How does your child react when disciplined? _____

When frustrated? _____

How does your child react when there are changes in schedule or changes around the house? _____

Have there been any serious illnesses, deaths, divorces, family moves or other experiences which seemed to have an effect on your child? ___ yes ___ no

If yes, please describe: _____

I hereby authorize the staff at Speech and Language Therapy and Rehabilitation Specialists to perform diagnostic tests for the evaluation of my child, _____. I understand that assessment may include an audiotaped or videotaped recording of my child's interactions. I understand that these tapes will be confidential and will not be used for any other purpose than for this assessment, unless written permission is provided by me for use in an educational setting.

Signature of parent or guardian

Date