



# SPEECH-LANGUAGE-HEARING CASE HISTORY FORM



## Identifying and Family Information:

Child's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Sex:  M  F  
 Father's Name: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 \_\_\_\_\_ E-mail: \_\_\_\_\_  
 \_\_\_\_\_  
 Mother's Name: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 \_\_\_\_\_ E-mail: \_\_\_\_\_  
 \_\_\_\_\_  
 Doctor's Name: \_\_\_\_\_ Doctor's Phone: \_\_\_\_\_

## 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

## Child's race/ethnic group:

- Caucasian, Non-Hispanic                       Hispanic                       African-American  
 Native American                       Asian or Pacific Islander                       Other \_\_\_\_\_

## 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? \_\_\_\_\_

# Speech-Language-Hearing

Do you feel your child has a speech problem?

Yes  No

If yes, please describe. \_\_\_\_\_

Do you feel your child has a hearing problem?

Yes  No

If yes, please describe. \_\_\_\_\_

Has he/she ever had a speech evaluation/screening?

Yes  No

If yes, where and when? \_\_\_\_\_

What were you told? \_\_\_\_\_

Has he/she ever had a hearing evaluation/screening?

Yes  No

If yes, where and when? \_\_\_\_\_

What were you told? \_\_\_\_\_

Has your child ever had speech therapy?

Yes  No

If yes, where and when? \_\_\_\_\_

What was he/she working on? \_\_\_\_\_

Has your child received any other evaluation or therapy (physical therapy, counseling, occupational therapy, vision, etc.)?

Yes  No

If yes, please describe. \_\_\_\_\_

Is your child aware of, or frustrated by, any speech/language difficulties? \_\_\_\_\_

What do you see as your child's most difficult problem in the home? \_\_\_\_\_

What do you see as your child's most difficult problem in school? \_\_\_\_\_

## Birth History

Was there anything unusual about the pregnancy or birth?  Yes  No  
If yes, please describe. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How old was the mother when the child was born? \_\_\_\_\_

Was the mother sick during the pregnancy?  Yes  No  
If yes, please describe. \_\_\_\_\_  
\_\_\_\_\_

How many months was the pregnancy? \_\_\_\_\_

Did the child go home with his/her mother from the hospital?  Yes  No  
If child stayed at the hospital, please describe why and how long. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Medical History

Has your child had any of the following?

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> adenoidectomy          | <input type="checkbox"/> encephalitis  | <input type="checkbox"/> seizures                   |
| <input type="checkbox"/> allergies              | <input type="checkbox"/> flu           | <input type="checkbox"/> sinusitis                  |
| <input type="checkbox"/> breathing difficulties | <input type="checkbox"/> head injury   | <input type="checkbox"/> sleeping difficulties      |
| <input type="checkbox"/> chicken pox            | <input type="checkbox"/> high fevers   | <input type="checkbox"/> thumb/finger sucking habit |
| <input type="checkbox"/> colds                  | <input type="checkbox"/> measles       | <input type="checkbox"/> tonsillectomy              |
| <input type="checkbox"/> ear infections         | <input type="checkbox"/> meningitis    | <input type="checkbox"/> tonsillitis                |
| How often? _____                                | <input type="checkbox"/> mumps         | <input type="checkbox"/> vision problems            |
| <input type="checkbox"/> ear tubes              | <input type="checkbox"/> scarlet fever |   |

Other serious injury/surgery: \_\_\_\_\_

Is your child currently (or recently) under a physician's care?  Yes  No  
If yes, why? \_\_\_\_\_  
\_\_\_\_\_

Please list any medications your child takes regularly: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Developmental History

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

\_\_\_\_\_ sat alone  
\_\_\_\_\_ babbled  
\_\_\_\_\_ put two words together  
\_\_\_\_\_ walked

\_\_\_\_\_ grasped crayon/pencil  
\_\_\_\_\_ said first words  
\_\_\_\_\_ spoke in short sentences  
\_\_\_\_\_ toilet trained

### 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?
- retrieve/point to common objects upon request (ball, cup, shoe)?
- 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 using...

- body language.
- sounds (vowels, grunting).
- words (shoe, doggy, up).
- 2 to 4 word sentences.
- sentences longer than four words.
- other \_\_\_\_\_.

### Behavioral Characteristics:

- cooperative
- attentive
- willing to try new activities
- plays alone for reasonable length of time
- separation difficulties
- easily frustrated/impulsive
- stubborn
- restless
- poor eye contact
- easily distracted/short attention
- destructive/aggressive
- withdrawn
- inappropriate behavior
- self-abusive behavior

**School History**

**If your child is in school, please answer the following:**

Name of school and grade in school: \_\_\_\_\_  
\_\_\_\_\_

Teacher's name: \_\_\_\_\_  
\_\_\_\_\_

Has your child repeated a grade? \_\_\_\_\_  
\_\_\_\_\_

What are your child's strengths and/or best subjects? \_\_\_\_\_  
\_\_\_\_\_

Is your child having difficulty with any subjects? \_\_\_\_\_  
\_\_\_\_\_

Is your child receiving help in any subjects? \_\_\_\_\_  
\_\_\_\_\_

**Additional Comments**

\_\_\_\_\_  
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