



Speech-Language-Hearing Case History Form

Child's Name:	Birthdate:
Sex: M F	Age:
Mother's Name:	Mother's: Cell #: Home #: Work #:
Mother's Address:	Mother's: Home email: Work email:
Father's Name:	Father's : Cell #: Home #: Work #:
Father's Address:	Father's : Home email: Work email:
Doctor's Name:	Doctor's Phone:

Child lives with (check one):

- Birth parents
 Foster Parents
 One Parent
 Adoptive Parents
 Parent & Step-Parent
 Other _____

Family History:

Siblings: _____ Age: _____

Is there a past family history of speech, language or hearing problems or learning/developmental disabilities? Yes No

If "yes," please comment here:

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? _____

Preferred language at home: _____

Birth & Medical History:

Was there anything unusual about the pregnancy or birth? ___ Yes ___ No

If yes, please explain:

How old was the mother when child was born? _____

How many months was the pregnancy? _____

Was the mother sick during pregnancy? _____

Birth Weight: _____

Has your child had any of the following?:

Adenoidectomy ___ High Fevers ___ Allergies ___ Head injury ___ Breathing Difficulties ___
Sleeping Difficulties ___ Chicken Pox ___ Thumb/Finger Sucking ___ Frequent Colds ___
Tonsillectomy ___ Frequent Ear Infections ___ Tonsillitis ___
Ear (PE) Tubes ___ Vision Problems ___ Sensory concerns ___ Tip Toe Walker ___

If you checked any, please provide details/dates:

Other serious illness/injury: _____

Medical Diagnoses: _____

Date of last hearing screening: _____ Results: _____

Date of last vision screening: _____ Results: _____

Hospitalizations: _____

Medications/Vitamins: _____

Developmental History:

Please tell the approximate age your child reached the following milestones:

- | | |
|-------------------------------|-----------------------------|
| ___ Sat Alone | ___ Grasped crayon/pencil |
| ___ Babbled | ___ Crawled |
| ___ Said first word(s) | ___ Puts two words together |
| ___ Spoke in short sentences | ___ Walked |
| ___ Completed toilet training | |

Oral Motor & Feeding History:

Has your child experienced feeding/eating difficulties (e.g., biting, swallowing, chewing)?

Yes/No _____

If yes, please explain: _____

Was your child breast-fed or bottle-fed? _____

Does your child eat by self-using utensils? Yes/No _____

Drool? Yes/No Suck Thumb? Yes/No If yes, since what age? _____

Use pacifier? Yes/No If yes, since what age? _____

Does your child put toys in mouth? Yes/No _____ If yes, please explain: _____

Does your child have food allergies? Yes/No _____

If yes, please explain: _____

Does your child have food preferences/aversions or food allergies? Yes/No

If yes, please explain: _____

Speech & Language Development:

How does your child prefer to communicate?

_____ gestures _____ words _____ both _____ neither

Number of words in a typical sentence? _____

Is your child's speech difficult to understand? _____

What types of speech errors does he/she exhibit?

Does your child: identify objects? _____ actions? _____

ask questions? _____ follow directions? _____

understand what you are saying? _____

respond correctly to yes/no questions? _____

respond correctly to "WH" (who, what etc.) questions? _____

play appropriately with toys? _____

have difficulty with routines and/or transitions such as bedtime, mealtime, or getting in the car? _____

Please provide examples of your child's speech/language:

Has your child ever received a speech/language evaluation? Yes/ No _____ Date _____

Has your child received speech/language therapy previously? Yes/No _____

If yes, when? For how long?

Can your child have food for therapy and/or rewards? Yes/No _____

If yes, please list any exceptions:

Please indicate your current concerns:

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?

School History:

School: _____

Grade: _____ Teacher: _____

Has your child ever repeated a grade? ____ If so, what grade? _____

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

Is your child having difficulty with a particular subject? _____

If yes, what subject? _____

Is your child receiving help at school or at home (i.e., support services, tutoring, etc.)?

Yes/No:_____ If yes, please explain: _____

Does your child have an IEP? _____ If so, please briefly describe the services your child receives:_____

(Please also provide a copy of the IEP at your first appointment)

Favorite Activities:

Please list your child's favorite activities, hobbies, toys, games, t.v. shows, etc.

What are their dislikes, if any:

What are your child's strengths?

Additional Concerns/Comments:

Thank you so much for your cooperation in completing this form!