

Speech-Language-Hearing Case History Form

Identifying Information:

Child's Name: _____ Date of Birth: _____
Parent's Name (s): _____ Home Phone : _____
Home Address: _____ Cell Phone: _____
_____ Work Phone: _____
Parent's Occupation(s): _____ / _____
Email Address: _____ / _____
Child's School: _____ Grade: _____ Teacher: _____
Referred By: _____
Doctor's Name: _____ Doctor's Phone: _____

Child lives with (check one):

- | | |
|---|---|
| <input type="checkbox"/> Birth Parent | <input type="checkbox"/> Foster Parents |
| <input type="checkbox"/> Adoptive Parents | <input type="checkbox"/> One Parent |
| <input type="checkbox"/> Parent & Step-parent | <input type="checkbox"/> Other: _____ |

Family History:

Siblings: _____ Age: _____

Is there a family history of :	Yes/No
Speech/Language Difficulties	_____
Hearing Impairment/Deafness	_____
Learning Difficulties	_____
Developmental Difficulties	_____

If you responded "yes" to any of the above, please describe:

Other Language Exposure:

Is there a language other than English spoken in the home? _____ Yes _____ No

If yes, which language? _____

Does the child speak this language? _____ Yes _____ No

Does the child understand this language? _____ Yes _____ No

Which language does the child prefer to speak at home? _____ school? _____

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 | _____ |

If you checked any, please provide details/dates:

Other serious illness/injury: _____

Date of last hearing screening: _____ Results: _____

Date of last vision screening: _____ Results: _____

Hospitalizations: _____

Medications: _____

Developmental History:

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

- | | |
|---------------------------------|------------------------------|
| _____ Sat Alone | _____ Grasped crayon/pencil |
| _____ Babbled | _____ Crawled |
| _____ Said first word(s) | _____ Put 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? _____

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? 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? _____

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:

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: _____

Favorite Activities:

Please list some of your child's favorite toys, games, hobbies, etc.

Additional Concerns:
