Speech Beginnings, PLC

Speech-Language Services: Evaluation and Therapy

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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):

___ Birth Parent
___ Adoptive Parents
___ Parent & Step-parent
___ Foster Parents
___ One Parent
___ 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
__________ Babbled
___________Said first word(s)
___________Spoke in short sentences
___________Completed toilet training
___________ Grasped crayon/pencil
___________ Crawled
___________ Put two words together
___________ Walked

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: