_____/____/____
Client No: _____

CHILD CASE HISTORY FORM

All questions contained in this questionnaire are strictly confidential and will become part of the child's record.

Name: _____ DOB _____/_____/_____
(Last, First, MI)
Address: _____ Home/cell phone: _____
City, State, ZIP _____ Work phone: _____
Best time to phone: _____
Previous or Referring Doctor: _____

FAMILY INFORMATION

Parents	Name	Age	Occupation	Highest Education Level

Name of person completing this questionnaire: _____
Relationship to child:_____
If the address of either parent is different from that of the child, please indicate below.
_____

Other children in the family:			
Name	Gender	Age	Any speech, language or hearing problems? Please explain.

Who referred you to the Speech, Language and Hearing Clinic? _____
Has your child received speech or language therapy in the past? _____
If so, who was the child's speech-language pathologist? _____
Is the child currently enrolled in therapy? _____ If so, where? _____
Child's doctor(s) _____
_____
Why are you seeking our services at this time?_____
_____
What do you expect to achieve from our services?_____
_____
When was the speech or language difficulty first noticed? _____
Who noticed it? _____

PRE-NATAL /BIRTH HISTORY

Biological mother's age at time of pregnancy: _____

Any medical problems before this pregnancy: Yes □ No □ If yes, please explain. _____

_____

Did the mother have any of the following during the pregnancy? German Measles □ Toxemia □
Accidents/Injuries □ Anemia □ Hospitalization □ Other □

Please explain above complications: _____

_____

Please check and explain all that apply:

□ Mother took medication during pregnancy _____
□ Child was born prematurely _____
□ Prolonged labor _____
□ Forceps used _____
□ Caesarean Section _____
□ Breech birth _____
□ Mother given drugs during labor/delivery _____
□ Low birth weight _____
□ Small for gestational age _____
□ Rh Factor _____
□ Child received oxygen at birth _____
□ Other complications _____

_____

DEVELOPMENTAL HISTORY

Please give ages which the following first occurred:

MILESTONE	AGE FIRST OCCURRED	MILESTONE	AGE FIRST OCCURRED
Held up head		Sat up unsupported	
Crawled		Reached for an object	
Stood		Walked unaided	
Ran		First tooth erupted	
First word		Put two words together	
Bladder trained		Bowel trained	
Night trained		Fed self	

Which hand does the child use most frequently? Right □ Left □ No preference □

Does your child have difficulty walking, running, or participating in other activities which require small or large muscle coordination? _____

Are there or have there ever been any feeding problems (e.g., problems with sucking, swallowing, drooling, chewing, etc.?) If yes, please describe. _____

Describe the child's response to sound (please check all that apply):
Responds to all sounds □ Responds to loud sounds □ Inconsistently responds to sounds □

MEDICAL HISTORY

Surgeries:	Reason:	Hospital:

Check all that apply: indicate age and describe where appropriate.	Age	Describe:
Condition:		
□ Adenoidectomy		
□ Allergies		
□ Asthma		
□ Blood disease		
□ Cataracts		
□ Chickenpox		
□ Chronic colds		
□ Convulsions		
□ Croup		
□ Dental problems/ Orthodontia		
□ Ear aches		
□ Ear infections		
□ Encephalitis		
□ Headaches		
□ Head injuries		
□ Heart problems		
□ Influenza		
□ Mastoidectomy		
□ Measles		
□ Muscle disorder		
□ Pneumonia		
□ Tonsillectomy		
□ Tonsillitis		
□ Other (please specify)		

Is your child's health Good □ Fair □ Poor □

Is your child now under medical treatment or on medication? Yes □ No □

List your child's prescribed drugs and over-the-counter drugs, (ex. Medications, vitamins, inhalers) _____

_____

Date of last vision test: _____ Results: _____

Date of last hearing test: _____ Results: _____

Does your child wear a hearing aid? Yes □ No □ Glasses? Yes □ No □ If yes, please explain.

_____

Date of comprehensive or behavioral evaluation(s): _____

_____

EVERY DAY INFORMATION

Is English the primary language in the home? Yes □ No □ If not, what is the primary language? _____

Please describe how your child interacts with others? (e.g., shy, aggressive, uncooperative, etc.) _____

_____

How does your child get along with other children? _____

_____

Does your child prefer to play alone? _____

Does your child have pretend play (pretends to go to work like mom/day, drinks pretend tea, etc.) _____

_____

What are your child's favorite TV shows? _____

_____

Does your child have a favorite stuffed animal or cartoon character? _____

_____

How does the child get along with brothers and sisters?_____

_____

What kinds of activities are engaged in by the whole family? _____

_____

What things does the child do particularly well? _____

EDUCATIONAL INFORMATION

Child's current grade level: _____

School:_____

Teacher(s):_____

How is your child doing academically? _____

If enrolled for special services, has an Individual Educational Plan (IEP) been developed? If yes, please describe your child's goals or attach a copy of his/her IEP. _____

_____

Please provide any additional information that may be helpful in the evaluation or treatment of your child.

_____

_____

_____

_____

_____

_____