



CREATIVE SPEECH SOLUTIONS, LLC

Pediatric Therapy Center

SPEECH AND LANGUAGE CASE HISTORY FORM

Date _____
Person filling out this questionnaire _____
Relationship to child _____

PLEASE ATTACH A
RECENT PHOTO OF YOUR
CHILD HERE

IDENTIFYING INFORMATION

Name of child _____
Nickname _____
Date of Birth _____ Child's age _____
Address _____
City _____ County _____ State _____ Zip _____
Home# _____ Cell# _____ Work# _____
Alternate phone number(s) _____
Email address: _____
I prefer to be contacted by: email _____ cell phone _____ work phone _____ home phone _____

Name	Age	Occupation	Education
Parent 1: _____	_____	_____	_____
Parent 2: _____	_____	_____	_____

If the address of either parent is different from that of the child, please indicate:

Other children in the family:

Name	Sex	Age	School-Grade
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Who can we thank for telling you about our practice? _____

Child's Doctor: _____ Address _____

Do you want a copy of our report sent to your child's doctor? Yes _____ No _____

To what other professional persons or agencies do you want a report sent? _____

STATEMENT OF THE PROBLEM

Describe in your own words what problem your child is having with speech, language, and/or hearing:

List any other concerns you have regarding your child's development:

Does your child have a formal diagnosis? Yes ___ No ___ If yes, what is it? _____

When was it made? _____ By whom? _____

SPEECH, LANGUAGE AND HEARING DEVELOPMENT

Did the child make babbling or cooing sounds during the first 6 months of life? _____

At what age did the child say his or her first word? _____

What were the child's first words? _____

Did the child keep adding words once he/she started to talk? Yes ___ No ___

If no, explain _____

At what age did the child begin using 2 and 3 word sentences? _____

Did speech learning ever seem to stop for a period of time? Yes ___ No ___

If yes, explain _____

Does your child talk a lot ___ occasionally ___ never ___

Does the child prefer to talk ___ gesture ___ talk and gesture ___

Does the child most frequently use sounds ___ single words ___ 2-word sentences ___

3-word sentences ___ more than 3-word sentences ___

List examples: _____

Does your child make sounds incorrectly? Yes ___ No ___ If yes, which ones? _____

Does your child hesitate, "get stuck," repeat or stutter on sounds or words? Yes ___ No ___

If yes, describe: _____

Describe any recent changes in the child's speech: _____

Can the child tell a simple story? Yes ___ No ___

How well can he/she be understood by the following individuals? (indicate "A" for all the time; "M" for most of the time; "S" for some of the time; or "R" for rarely)

Parents ___ Siblings ___ Teacher(s) ___ Friends ___ Strangers ___

Comments _____

Does the child seem to understand what you say to him or her? Yes ___ No ___

If no, explain _____

Does your child consistently answer to his/her name? Yes ___ No ___

Does your child make appropriate eye contact with adults? Yes ___ No ___ Other children? Yes ___ No ___

Does your child follow simple commands? Yes _____ No _____

Please describe/give examples: _____

Does your child ever have trouble remembering what you have told him or her? Yes _____ No _____

If yes, explain? _____

Does your child enjoy looking at books? Yes _____ No _____ How often do you read to your child? _____

DEVELOPMENTAL HISTORY

Check which is applicable: This is our biological _____ foster _____ adopted _____ child

Did the mother have medical problems during the pregnancy? Yes _____ No _____

If yes, please describe, including medical attention: _____

Did the mother take any prescription and/or nonprescription medication during this pregnancy? Yes _____ No _____

If yes, what kind(s)? _____

Was the child full-term? Yes _____ No _____ If no, what was the gestational age? _____

Was the delivery normal? Yes _____ No _____ If no, explain _____

Caesarian? Yes _____ No _____ If yes, reason? _____

How long were the mother and child in the hospital? _____

Child's weight at birth? _____ Any birth injuries? _____ Was the child an RH baby? _____

What special medication attention or treatment did the child receive at birth, if any? _____

Breast or bottle-fed? _____ If breast-fed, for how long? _____

Any difficulties transitioning from breast to bottle? _____ Age when weaned off bottle _____

Were there any feeding difficulties during infancy Yes _____ No _____

If yes, describe _____

Weight after one year _____ Present weight _____

What age did your child begin puree foods (e.g., rice cereal, Stage I jarred foods)? _____

Soft chewables _____ Table food _____

Did the child have difficulty transitioning to different food textures? Yes _____ No _____

If yes, explain _____

Does your child have a limited diet due to "picky eating?" Yes _____ No _____

If yes, describe _____

Does your child have any food allergies? Yes _____ No _____

If yes please list: _____

Does your child have any known gastrointestinal issues? Yes _____ No _____

If yes, explain _____

Check all that apply: Child finger feeds _____ uses a fork _____ a spoon _____ an open cup _____ a straw _____

Is adult assistance needed with feeding? Yes _____ No _____

If yes, explain _____

Has he/she ever choked on solid foods? Yes _____ No _____ Does your child cough on liquids? Yes _____ No _____

Can your child chew well? Yes _____ No _____ Does he/she drool? Yes _____ No _____ If yes, when? _____

Did child use pacifier? Yes _____ No _____ If yes, age weaned from pacifier _____

Does child continue to mouthe objects? Yes _____ No _____

Did child suck his/her thumb/fingers? Yes _____ No _____ If yes, until when? _____

Does your child suck on his/her hair/clothing/blanket/etc? Yes _____ No _____ If yes, what? _____

Does child resist tooth brushing? Yes _____ No _____ Does he/she like taking a bath? Yes _____ No _____

Swings? Yes _____ No _____ Parties? Yes _____ No _____ Rough housing? Yes _____ No _____

Child prefers to primarily play: alone _____ with other children _____ with older children _____ with younger children _____ with adults _____

Is your child overly sensitive to loud sounds? Yes _____ No _____ Bright lights? Yes _____ No _____

Tags on clothing? Yes _____ No _____

Give ages at which the following first occurred:

Sat up _____ Crawled _____ Stood _____ Walked _____ Ran _____

Bladder trained _____ Bowel trained _____ Night trained _____

Which hand does the child use more frequently? Right _____ Left _____ No preference _____

FAMILY HISTORY

Are there any members of your immediate family that have been diagnosed with any of the following:

(Please indicate "F" for father, "M" for mother, or "S" for sibling)

_____ learning disability

_____ dyslexia

_____ speech and language delay/disorder

_____ sensory processing disorder

_____ auditory processing disorder

_____ ADD/ADHD

_____ autistic spectrum disorder/PDD

_____ other, please explain _____

MEDICAL HISTORY

Please list age, type of treatment, and/or number of recurrences next to those that apply

ILLNESS	Age	Treatment	Recurrence	ILLNESS	Age	Treatment	Recurrence
Allergies				Ear Infections			
Asthma				Orthodontia			
Chronic colds				Seizures			
Dental problems				Tonsillitis			

Describe any other illnesses, accidents, injuries, and hospitalizations of the child (include child's age)

If your child underwent any surgery, please describe (include date of surgery and surgeon's name)

Is the child's health good? _____ Fair _____ Poor _____ Is the child now under medical treatment or on medication? Yes _____ No _____ If yes please explain: _____

MEDICAL EXAMINATION HISTORY

Month/year of last PHYSICAL EXAM _____ Doctor _____

Results: _____

Month/year of last VISION TEST _____ Doctor _____

Results: _____

Month/year of last HEARING TEST _____ Doctor _____

Results: _____

Did/does child wear a hearing aid? Yes _____ No _____ Glasses? Yes _____ No _____

If yes, explain: _____

Dates of other pertinent medical examinations (e.g., neurological, psychological and ENT):

Date _____ Doctor _____ Results: _____

Date _____ Doctor _____ Results: _____

Date _____ Doctor _____ Results: _____

EDUCATIONAL HISTORY

Does your child attend? Daycare _____ Preschool _____ Kindergarten _____ Grade School _____

Name of School _____ Grade/Level _____

In school, does he/she do: average _____ below average _____ above average _____ work

What are the child's best subjects? _____

Has he or she repeated a grade? Yes _____ No _____ If yes, which one(s)? _____

What is your impression of your child's learning abilities? _____

What is your impression of your child's social skills? _____

