CREATIVE SPEECH SOLUTIONS, LLC

Pediatric Therapy Center

SPEECH AND LANGUAGE CASE HISTORY FORM

PLEASE ATTACH A RECENT PHOTO OF YOUR CHILD HERE

Date_____

Person filling out this questionnaire_____

Relationship to child _____

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? _____

Does your child display any behavioral or attentional issues at school? _____

Describe any speech, language, hearing, OT, PT, psychological, special education services, tutoring that the child is receiving/has received.

Type of Therapy	Therapist	Frequency	Place (Private/School)	Group or Individual?	Duration (e.g., age 3-5)