**CREATIVE SPEECH SOLUTIONS, LLC**

*Pediatric Therapy Center*

# LITERACY CASE HISTORY FORM

*Please bring samples of work that your child is experiencing difficulty with (e.g., writing, reading, spelling) on the day of the evaluation.*

PLEASE ATTACH A RECENT PHOTO OF YOUR CHILD HERE

Date_____

Person filling out this questionnaire_____

Relationship to child _____

Child's Doctor:_____

Address_____

_____

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

_____

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 (please provide name/address)?

_____

_____

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

## IDENTIFYING INFORMATION

Name of child_____Nickname_____

Date of Birth _____ Child's age _____

Address_____

City_____State_____Zip_____

Home#_____Cell#_____Work#_____

Alternate phone #_____Email address _____

I prefer to be contacted by: email_____ cell phone_____ work phone_____ home phone_____

## STATEMENT OF THE PROBLEM

Describe what problem(s) your child is having with phonics, reading, spelling, and/or writing:

_____

_____

_____

_____

Does your child have any speech, language or hearing disorders or challenges? Yes____ No___

If yes, please describe _____

_____

_____

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?_____

FAMILY HISTORY

| | Name | Age | Occupation | Education |
|---|---|---|---|---|
| Parent 1: | | | | |
| Parent 2: | | | | |

Other children in the family:

| Name | Sex | Age | School-Grade |
|---|---|---|---|
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| | | | |

Have any members of your immediate family been diagnosed with any of the following:

*(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 _____

## BIRTH 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 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?_____

Were there complications during delivery? Yes_____ No_____ If yes, 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? Yes_____ No_____ If yes, explain _____

_____Was the child an RH baby?_____

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

_____

## 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 (include child's age).

_____

_____

_____

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

_____

_____

_____

Child's health is 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? _____

_____

_____

_____

Has your child ever been referred to the Child Study Team in your district? Yes___ No___

If yes, when? _____

Was a Child Study Team evaluation conducted? Yes___ No___If yes, what were the results of the evaluation?

_____

_____

_____

_____

Has your child had an IEP in the past? Yes___ No___ Does he/she currently have an IEP? Yes___ No____

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

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