Date:_____

Case History

Child's Name: _____ Age:_____

DOB:_____ Gender: ☐ Male ☐ Female

Completed by: _____ Relationship to Child:_____

Child's Address:_____ City:_____ Zip:_____

Family History:

Father's Name:_____

Present Occupation:_____

History of Speech Disorder: ☐ No ☐ Yes

If yes, type of speech disorder and was therapy ever provided:_____

Mother's Name:_____

Present Occupation:_____

History of Speech Disorder: ☐ No ☐ Yes

If yes, type of speech disorder and was therapy ever provided:_____

Sibling's name:	Age:	Gender:	Speech Disorder:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Any additional family history relevant to speech and language disorders:

_____

Other languages spoken at home:_____

Physiological Information:

Child's Current Health Status: ☐Excellent ☐Good ☐Fair ☐Poor

Child's current weight:_____ Child's current height:_____

Date of most recent physical examination or doctor's visit:_____

Current pediatrician's name: _____Phone: _____

Has your child had any of the following?

(Please check ALL that apply and list age of occurrence if applicable):

Chicken Pox ☐	Measles ☐	Scarlet Fever ☐
Pneumonia Influenza ☐	Asthma ☐	Hay Fever ☐
Seizures ☐	Asthma ☐	Mumps ☐
Allergies ☐	High Fev ☐	Whooping Coug ☐
Ear Infections ☐	Meningit ☐	Respiratory Illn ☐

Surgeries/Infection (i.e., tonsils removed, adenoids removed)? ☐ No ☐ Yes

If yes, please list surgery and when it occurred: _____

Hearing:

Does your child have a history of ear infections? ☐No ☐Yes

If yes, how many?:_____ Age of first occurrence?:_____

When was last occurrence?:_____

Has your child ever had pressure equalizing (PE) tubes inserted? ☐No☐Yes

If yes, when were they inserted?:_____ In both ears?:_____

Currently still in place?:_____

Has your child's hearing ever been screened or tested?☐No ☐Yes

If yes, results:_____

Any hearing concerns/issues at this time:_____

Delivery:

Mother's health during pregnancy:_____

Length of Labor:_____ Birth Weight:_____

Delivery: ☐Breech ☐C-Section ☐Vaginal

Was child born premature? ☐No ☐Yes, at ____ weeks

Feeding: ☐Breast-fed ☐Bottle-fed ☐Nutritional Disturbances

Any complications during pregnancy or delivery?_____

Developmental Milestones:

Activity:	**Age:**
Sitting Alone	
Crawling	
Walking	
Dressing	
Self-Feeding	
Use single word	
Combine words	
Name simple objects	
Use simple questions	

Does your child have a specific diagnosis at this time (i.e., Autism, ADHD, etc.)?

☐No ☐Yes

If yes, please explain when diagnosed and by whom:_____

School History (if applicable):

School:_____ Grade:_____

Does your child have an IEP? ☐No ☐Yes

Does your child receive any special services in school? ☐No ☐Yes

If yes, please list services: _____

Speech History:

What concerns do you have regarding your child's speech and language development? _____

When did you first become concerned? _____

Is your child easily understood by family members? ☐No ☐Yes Others:☐No☐Yes

Has your child ever had their speech and language skills evaluated in the past? ☐No ☐Yes

If yes, please provide dates and agency:_____

Has your child ever received speech and language therapy in the past? ☐No ☐Yes

If yes, please provide dates and agency:_____

Has your child ever received any special other therapies (i.e., OT, PT)? ☐No ☐Yes

If yes, please provide type, dates and agency:_____

What are your child's interests/favorite toys?_____

Additional Pertinent Information:_____

_____

_____

_____

_____