Child Case History Form

Please complete all relevant information and return to the clinic when you come for your first appointment. Some questions may not apply to your child, feel free to leave those blank.

I. General Information

Child's Name: _____ Birth Date: _____ Gender: _____

Address: _____ City: _____ Zip: _____

Primary Contact: _____ Preferred Phone: _____

Email address: _____

Person completing this form: _____

Relationship to child: _____ Language(s) spoken in the home: _____

II Reason for Referral

Are you interested in: ☐ Evaluation ☐ Treatment ☐ Evaluation and Treatment

What are your concerns regarding your child's speech and/or language?

III Background Information

Parent's Name: _____

Parent's Name: _____

Siblings Name	Age	Gender	Grade	Problem Type

Please describe other family history of speech, language or hearing problems if present:

IV. Birth History

If there was there anything unusual about the pregnancy or birth please describe:

Were there any feeding problems? ☐ Yes ☐ No

V. Developmental History

Motor Development

Milestone	Age		Milestone	Age
Sat unsupported			Fed Self	
Crawled			Toilet trained	
Walked			Dress Self	

Compared to other children your child's age, describe how he or she is able to sit, stand, run, and use his or her hands:

Speech and Language Development

Milestone	Age		Milestone	Age
Babbled			Put words together	
Used first word			Use short sentences	

How does your child currently communicate? For example, gestures, single words, phrases, complete sentences?

If your child is beginning talk which of the following apply?

- ☐ Babbles
- ☐ Uses gestures to communicate
- ☐ Uses exclamations such as "oh!" "ah oh"
- ☐ Babbles and "talks" back and forth with familiar adults
- ☐ Imitates your words
- ☐ Makes sound effect and animal noises

How does your child's voice sound?

☐ Normal ☐ Too high pitched ☐ Too low pitched ☐ Hoarse ☐ Nasal

Does your child have difficulty making any particular speech sounds? ☐ Yes ☐ No

If so, which ones? _____

Do others outside your family have trouble understanding your child? ☐ Yes ☐ No

Does your child seem to be aware of speaking differently than others? ☐ Yes ☐ No

Does your child seem to have difficulty understanding speech or directions? ☐ Yes ☐ No

Is your child frustrated by his or her communication difficulties? ☐ Yes ☐ No

Does your child tell you stories about their day? ☐ Yes ☐ No

Does your child participate in saying nursery rhymes and chants with you? ☐ Yes ☐ No

Does your child enjoy reading books with you? ☐ Yes ☐ No

Does you child read independently? ☐ Yes ☐ No

If so, does your child describe what they have been reading to you? ☐ Yes ☐ No

If your child experiences reading difficulties please describe.

On average, how much screen time (TV, video, iPad, phone etc) does your child experience

Daily: _____ Weekly: _____

Check any of the following that apply to your child:

	If so, when was it diagnosed or when did it occur?
☐ Sucking problems	
☐ Swallowing problems	
☐ Feeding problems	
☐ Seizures	
☐ Snoring/mouth breathing	
☐ Adenoidectomy	
☐ Tonsillectomy	
☐ Finger/thumb sucking	
☐ Attention Deficit Disorder	
☐ Hearing Loss	
☐ Frequent ear infections	
☐ PE tubes	
☐ Hearing aids	
☐ Vision problems	
☐ Autism	
☐ Cleft Lip and/or Palate	
☐ Down Syndrome	
☐ Developmental delays	

Please describe other medical problems if present:

Please specify any allergies your child has:

VI. Previous Evaluations

Type of evaluation	When/Where	Result

VII. Previous Treatment

Type of Treatment	When/Where	Goals of treatment

VIII. Educational and Emotional History

What school is your child enrolled in? _____ Grade _____

Does your child have an Individualized Education Plan (IEP) ☐ Yes ☐ No

If yes, what services are provided on the IEP?

Has your child ever received special help or been in a special class in school? ☐ Yes ☐ No

If yes, please describe

Has your child exhibited any social and/or emotional problems? ☐ Yes ☐ No

If yes, please describe

What are your child's strengths and/or best subjects? ☐ Yes ☐ No

What subject(s) does your child have difficulty with, if any? ☐ Yes ☐ No

Does your child have/show any of the following behaviors?

☐ Demands attention	☐ Lacks confidence	☐ Unusually stressed
☐ Under active	☐ Short attention span	☐ Over active
☐ Impulsive	☐ Easily distracted	☐ Easily frustrated
☐ Withdrawn	☐ Needs high structure	☐ Talks excessively
☐ Overly sensitive to noise	☐ Poor eater	☐ Aggressive
☐ Prefers to play alone	☐ Difficulty following directions	

IX. Comments

Please provide any additional information that will aid us in evaluating your child.

X. Privacy

Would you like our clinic to share your child's treatment information (goals progress, etc.) with another agency? ☐ Yes ☐ No

If yes, which agency? _____

Occasionally students in the field of Communication Disorders observe therapy sessions. Check "Yes" if you agree to student observation of your child's session. ☐ Yes ☐ No

Finally, how did you hear about us?

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