Case History

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Today's date_____
Person completing this form _____ Relationship to child _____

General Information
Child's name _____ Date of birth _____ Age _____
Address _____
City_____ State_____ Zip_____

Family Information

	NAME	AGE	OCCUPATION
Parent 1:	_____	_____	_____
Parent 2:	_____	_____	_____

Cell # _____ Home # _____
Email address _____

Name and age of other children in the family _____
_____
List all of the people living in the child's home _____
_____
What language(s) are spoken in the home? _____
Please describe any family history of speech or language problems _____
_____
_____

Speech and Language
In your own words, describe your child's current speech/language problem:
_____
_____
_____
Does your child have a formal diagnosis? YES NO If so, what is it? _____
Did your child coo & babble in the first six months of life? YES NO
Age of first spoken words _____ What was it? _____
Age of first spoken sentence _____
Does your child talk: A LOT OCCASIONALLY NEVER

Does your child make sounds incorrectly? YES NO If so, what sounds?_____
_____
Does your child hesitate, get stuck, or repeat sounds or words? YES NO
Can your child tell a simple story? YES NO
Does your child seem to understand what is said to him or her? YES NO
What is your impression of your child's social skills? _____
Is your child aware of, or frustrated by any speech language difficulties? YES NO
What do you see as your child's most difficult problem at home? _____
_____
What do you see as your child's most difficult problem at school? _____
_____

History

Was the child full-term? YES NO If no, what was the gestational age? _____
Child's weight at birth _____
Were there any feeding difficulties during infancy? YES NO
If yes, describe _____
_____
Does your child have any current feeding difficulties? YES NO
If yes, describe _____
_____
Does your child have any food allergies? YES NO
If yes, please list: _____
Did your child use a pacifier? YES NO If yes, age weaned from pacifier _____
Does your child continue to put objects in his/her mouth? YES NO
Did your child suck his/her thumb/fingers? YES NO If yes, until when? _____
Does your child resist tooth brushing? YES NO
Does he/she like taking a bath? YES NO
Is your child overly sensitive to loud sounds? YES NO Bright lights? YES NO

Medical History

Describe any illnesses, accidents, injuries, and hospitalizations of the child (include child's age) _____
_____
_____
Is your child currently in good health? YES NO
Is your child currently taking any medication? YES NO
If so, what? _____
Has your child had his/her hearing checked? YES NO
If yes, what were the results? _____

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