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SPEECH-LANGUAGE CASE HISTORY

Patient Name:
Date:
Person filling out questionnaire:
Relationship to child:

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 was it made?

SPEECH, LANGUAGE AND HEARING DEVELOPMENT

Did your child make babbling or cooing sounds during the first 6 months of life? Yes ☐ No ☐
At what age did your child say his or her first word?
What were your child's first words?
Did your child keep adding words once he/she started to talk? Yes ☐ No ☐ If no, please explain:
At what age did your child begin using 2 and 3 word sentences?
Did speech learning ever seem to stop for a period of time? Yes ☐ No ☐ If yes, please explain:
Does your child talk: A lot ☐ Occasionally ☐ Never ☐

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Does your child prefer to: Talk ☐ Gesture ☐ Talk and Gesture ☐

Does your 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, please describe:

Describe any recent changes in your child's speech:

Can your child tell a simple story? Yes ☐ No ☐

How well can your child be understood by the following individuals? Check the boxes that apply.

	Always	Mostly	Sometimes	Rarely
Parents				
Siblings				
Teacher(s)				
Friends				
Strangers				

Does your child seem to understand what you say to him or her? Yes ☐ No ☐
If no, please explain:

Does your child consistently answer to his/her name? Yes ☐ No ☐

Does your child make appropriate eye contact with: Adults ☐ Other children ☐

Does your child follow simple commands? Yes ☐ No ☐
If yes, please describe/give examples:

Does your child ever have trouble remembering what you have told him or her? Yes ☐ No ☐
If yes, please explain:

Does your child enjoy looking at books? Yes ☐ No ☐

How often do you read to your child?

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DEVELOPMENTAL HISTORY

Is your child: Biological ☐ Foster ☐ Adopted ☐
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 your child full-term? Yes ☐ No ☐ If no, what was the gestational age?
Was your child's delivery normal? Yes ☐ No ☐ If no, please explain:
Was your child's delivery via caesarian? Yes ☐ No ☐ If yes, please give the reason:
How long were the mother and child in the hospital?
You child's weight at birth?
Any birth injuries?
What special medication attention or treatment did your child receive at birth, if any?
Was your baby: Breast-fed ☐ Bottle-fed ☐ If breast-fed, for how long?
Any difficulties transitioning from breast to bottle? Yes ☐ No ☐ If yes, please describe:
What was your child's age when weaned off the bottle?
Were there any feeding difficulties during infancy? Yes ☐ No ☐ If yes, please describe:
What was your child's weight at one year old?
What is your child's present weight?
What age did your child begin puree foods (e.g., rice cereal, stage I jar foods)?

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What age did your child begin soft chewable food?
What age did your child begin table food?
Did your child have difficulty transitioning to different food textures? Yes ☐ No ☐ If yes, please explain:
Does your child have a limited diet due to "picky eating"? Yes ☐ No ☐ If yes, please 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, please explain:
Does your child: Finger feed ☐ Use a fork ☐ Use a spoon ☐ Use an open cup ☐ Use a straw ☐
Is adult assistance needed with feeding your child? Yes ☐ No ☐ If yes, please explain:
Has your child ever choked on solid foods? Yes ☐ No ☐
Does your child cough on liquids? Yes ☐ No ☐
Can your child chew well? Yes ☐ No ☐
Does your child drool? Yes ☐ No ☐ If yes, when?
Did your child use a pacifier? Yes ☐ No ☐ If yes, age weaned off pacifier:
Does your child continue to mouth objects? Yes ☐ No ☐
Did your 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 your child resist tooth brushing? Yes ☐ No ☐

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Does your child like taking a bath? Yes ☐ No ☐

Does your child like swings? Yes ☐ No ☐

Does your child like parties? Yes ☐ No ☐

Does your child like rough housing? Yes ☐ No ☐

Does your child prefer 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 ☐

Is your child overly sensitive to bright lights? Yes ☐ No ☐

Is your child overly sensitive to tags on clothing? Yes ☐ No ☐

When did your child do the following:

Activity	Age	Activity	Age
Sat up:		Ran:	
Crawled:		Bladder trained:	
Stood:		Bowel trained:	
Walked:		Night trained:	

Which hand does your 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:

DIAGNOSIS	FATHER	MOTHER	SIBLING
Learning Disability			
Dyslexia			
Speech and Language Delay/Disorder			
Sensory Processing Disorder			
Auditory Processing Disorder			
ADD/ADHD			
Autistic Spectrum Disorder/PDD			
Other, please explain:			

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MEDICAL HISTORY

Please list age, type of treatment, and/or number of recurrences next to those that apply

ILLNESS	AGE	TREATMENT	RECURRENCE
Allergies			
Asthma			
Chronic Colds			
Dental Problems			
Ear Infections			
Orthodontia			
Seizures			
Tonsillitis			

Describe any other illnesses, accidents, injuries, and hospitalizations of your child (include child's age):

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

Is your child's health: Good ☐ Fair ☐ Poor ☐

Is your child now under medical treatment or on medication? Yes ☐ No ☐
If yes, please explain:

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

TYPE OF THERAPY	THERAPIST	FREQUENCY	PLACE (PRIVATE/SCHOOL)	GROUP OR INDIVIDUAL	DURATION (E.G. AGE 3-5)

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MEDICAL EXAMINATION HISTORY

EXAMINATION	MONTH	YEAR	DOCTOR	RESULTS
Last Physical Exam:				
Last Vision Test:				
Last Hearing Test:				
Other: ____________				
Other: ____________				
Other: ____________				

Did/does your child wear a hearing aid? Yes ☐ No ☐
If yes, please explain:

Did/does your child wear glasses? Yes ☐ No ☐
If yes, please explain:

EDUCATIONAL HISTORY

Does your child attend? Daycare ☐ Preschool ☐ Kindergarten☐ Grade School ☐

Name of school:

Grade/Level:

In school, does your child do: Average ☐ Below Average ☐ Above Average ☐

What are your child's best subjects?

Has your child 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?