Case History Form

Identifying Information:
Child's Name: _____ Date of Birth: _____
Parent's Name (s): _____ Home Phone : _____
Home Address: _____ Cell Phone: _____
_____ Work Phone: _____
Parent's Occupation:_____
Email Address: _____/_____
Child's School: _____ Grade: ____ Teacher:_____
Referred By: _____
Doctor's Name: _____ Doctor's Phone: _____

Child lives with (check one):
___ Birth Parent ___ Foster Parents
___ Adoptive Parents ___ One Parent
___ Parent & Step-parent ___ Other: _____

Family History:
Siblings: _____ Age:_____

Is there a family history of : Yes/No
Speech/Language Difficulties _____
Hearing Impairment/Deafness _____
Learning Difficulties _____
Developmental Difficulties _____
If you responded "yes" to any of the above, please describe:
Other Language Exposure:
Is there a language other than English spoken in the home? _____ Yes _____ No
If yes, which language? _____
Does the child speak this language? _____ Yes _____ No
Does the child understand this language? _____ Yes _____No
Which language does the child prefer to speak at home? _____ school? _____

Birth & Medical History:
Was there anything unusual about the pregnancy or birth? _____ Yes _____ No
If yes, please explain:
How old was the mother when child was born? _____

How many months was the pregnancy? _____
Was the mother sick during pregnancy? _____
Child's Birth Weight: _____
Has your child had any of the following:
Adenoidectomy ____ High Fevers ____
Allergies ____ Head injury ____
Breathing Difficulties ____ Sleeping Difficulties ____
Chicken Pox ____ Thumb/Finger Sucking ____
Frequent Colds ____ Tonsillectomy ____
Frequent Ear Infections ____ Tonsillitis ____
Ear (PE) Tubes ____ Vision Problems ____
If you checked any, please provide details/dates:
Other serious illness/injury: _____
Date of last hearing screening: _____ Results: _____
Date of last vision screening: _____ Results: _____
Hospitalizations: _____
Medications: _____

Developmental History:
Please tell the approximate age your child reached the following milestones:
_____ Sat Alone _____ Grasped crayon/pencil
_____ Babbled _____ Crawled
_____Said first word(s) _____ Put two words together
_____Spoke in short sentences _____ Walked
_____Completed toilet training

Oral Motor & Feeding History:
Has your child experienced feeding/eating difficulties (e.g., biting, swallowing, chewing)?
Yes/No _____
If yes, please explain: _____
Was your child breast-fed or bottle-fed? _____
Does your child eat by self using utensils? Yes/No _____ Drool? _____
Does your child put toys in mouth? Yes/No _____
If yes, please explain: _____
Does your child have food allergies? Yes/No _____If yes, please explain:
_____
Does your child have food preferences/aversions? Yes/No _____
If yes, please explain: _____

Speech & Language Development:
How does your child prefer to communicate?
_____ gestures _____ words _____ both _____ neither
Number of words in a typical sentence? _____
Is your child's speech difficult to understand? _____
What types of speech errors does he/she exhibit?
Does your child: identify objects? _____ actions? _____

ask questions? _____ follow directions? _____
understand what you are saying? _____
respond correctly to yes/no questions? _____
respond correctly to "WH" (who, what etc.) questions? _____
Please provide examples of your child's speech/language:
Has your child ever received a speech/language evaluation? Yes/ No _____ Date_____
Has your child received speech/language therapy previously? Yes/No _____
If yes, when? For how long? _____
Can your child have food for therapy and/or rewards? Yes/No _____
If yes, please list any exceptions: _____
Please indicate your current concerns:
Is your child aware of, or frustrated by, any speech/language difficulties? _____
What do you see as your child's most difficult problem in the home?
What do you see as your child's most difficult problem in school?

School History:
Has your child ever repeated a grade? _____ If so, what grade? _____
What are your child's strengths and/or best subjects? _____
Is your child having difficulty with a particular subject? _____
If yes, what subject? _____
Is your child receiving help at school or at home (i.e., support services, tutoring, etc.)?
Yes/No:_____ If yes, please explain: _____

Favorite Activities:
Please list your child's favorite activities, hobbies, toys, games etc.
_____
_____
_____
_____
_____
Additional Concerns/Comments: