Speech-Language Case History

Client Information

Date: _____

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

Address: _____ Male: _____ Female:_____

Person Completing Form:_____

Relationship to Child:_____

Phone Numbers: Home _____ Cell_____

E-mail:_____

Mother or Guardian's Name: _____

Education:_____ Occupation: _____

Employer:_____ Work Phone: _____

Marital Status of Parents: Married_____ Divorced _____ Single_____ Widow_____

Father's or Guardian's Name:_____

Education:_____ Occupation: _____

Employer:_____ Work Phone: _____

List children and adults living in the home (including name, age, and relationship)

_____

_____

_____

_____

Comments/Concerns: _____

_____

_____

_____

History

Medical and Developmental

Child's Pediatrician: _____
Other Physicians: _____

Was your child born full term? _____ Number of weeks: _____Birth Weight: _____

Unusual circumstances during pregnancy or delivery with this child? ◯Yes ◯No

If yes. explain:_____
_____
_____
_____

Does your child have any allergies?_____

Has your child had the following checked? Vision: ◯Yes ◯No Hearing: ◯Yes ◯No

Tubes in Ears?: ◯Yes ◯No Number of Ear Infections?_____

Comments: _____

At approximately what age did your child:

Sit Unassisted: _____
Crawl: _____
Walk: _____
Use Pacifier: _____
Say First Word: _____
Speak In Sentences: _____
Use Sippy Cup: _____

Did your child ever have difficulty with feeding and/or eating (sucking, chewing, swallowing, choking)? _____
_____

Are there any medical precautions? _____

List medications, dosage and frequency: _____
_____
_____

Describe other medical information: _____
_____
_____
_____
_____

Speech and Language

Describe the speech and language problem:_____
_____
_____
_____

When this problem was first noticed?_____

Has the problem: Improved?_____ Worsened?_____ Remained the same? _____

Did your child acquire speech then slow down or stop talking? ◯Yes ◯No Age_____

Is your child bilingual? ◯Yes ◯No

What languages your child speak? _____

What is the primary language spoken in the home?_____

Which of the following does your child use most frequently to communicate?
Complete Sentences_____ Single Words_____ Unintelligible Sounds _____
Gestures_____ Multiple Word Phrases, Not Sentences_____ Other_____

Does your child have difficulty producing specific speech sounds? ◯Yes ◯No
Which sounds? _____

How well can your child be understood by: Parents?_____ Strangers?_____
Siblings? _____ Playmates? _____ Relatives? _____

When you speak (not point) to your child, does the child understand? (CHECK ONE)
◯Everything ◯Most Everything ◯Very Little

Has your child's speech problem affected the following: (Describe)
Social interactions with peers? _____
Willingness to talk to others? _____
Classroom participation? _____
Self-esteem? _____

Does your child's speech pattern improve with certain speaking situations?
_____
_____

Does your child's speech pattern worsen with certain speaking situations?
_____
_____

Approximately how many different words does your child use?

_____

Are there any family members that have a history of a speech or language problems?

_____

_____

What concerns you *most* right now regarding your child's speech and language development?

_____

_____

_____

Educational

(Complete this section IF your child is in school)

Name of School: _____Grade:_____

City: _____Name of Teacher:_____

What is your impression of your child's learning abilities?

_____

_____

Is there an active IEP for your child? _____

What supportive services is your child currently receiving? _____

_____

Previous Testing

Has your child had therapy before this time?

Speech Therapy:	_____	Dates: _____
Occupational Therapy:	_____	Dates: _____
Physical Therapy:	_____	Dates: _____
Behavioral Therapy:	_____	Dates: _____
Psychological Therapy:	_____	Dates: _____

Comments about therapies:_____

_____

Goals

Goals for my child's therapy are:_____

_____

_____