CHILD CASE HISTORY

Thank you for taking the time to complete this form. This information will help us better serve you and your child. This information is confidential and will not be divulged to other persons or agencies without a signed release of information from you.

Date:_____

I. GENERAL INFORMATION

Child's Name: _____

Date of Birth: _____ Age: _____

Phone: ( )_____ ( )_____
(Home) (Work)

Referred by: _____

Informant: _____ Relationship to child: _____

Reason for referral: _____

_____

What do you hope to gain from this evaluation? _____

_____

_____

What are the main concerns you have regarding your child's speech and language? _____

_____

_____

_____

_____

_____

_____

II. FAMILY HISTORY

Father's Name: _____Occupation:_____Age:____

Mother's Name:_____Occupation:_____Age:____

My child is:_____Natural Child:_____Adopted Child

Sisters: Name: _____Age: _____Natural:_____Adopted:_____

_____ _____ _____ _____

_____ _____ _____ _____

Brothers: Name: _____Age: _____Natural:_____Adopted:_____

_____ _____ _____ _____

_____ _____ _____ _____

Other individuals living in the household:_____

Marital History:_____

Languages, other than English, spoken in the home:_____

Please describe any speech/language/learning problems of other family members (past or present):_____

_____

_____

III. PREGNANCY

Number of pregnancies_____Miscarriages:_____Stillbirths:_____

Duration of pregnancy:_____weeks

Mother's health during pregnancy:_____

Describe any diseases, health problems, hospitalizations etc. Mother experienced during pregnancy:_____

_____

Did you experience any of the following problems during pregnancy? Check all that apply:

_____Anemia	_____high blood pressure	_____accidents/serious injury
_____Diabetes	_____Spotting/bleeding	_____emotional stress
_____RH neg.	_____swelling	_____communicable disease
_____Toxemia	_____seizures	_____viral infection
_____Excessive Weight gain/loss	_____substance use (smoking-alcohol-drugs)	

Comments:_____

_____

Duration of labor: _____hours Child's birth weight _____

Anesthesia, if used: _____none _____general _____spinal _____other

Labor: _____spontaneous _____induced

Length of hard labor: _____

Presentation: Head first_____ feet first_____ buttocks_____

Cord around neck:_____

Delivery: _____spontaneous _____assisted, e.g., forceps

_____Breech _____C-section

Comments:_____

_____

Condition of mother after birth:_____

Was child SGA? _____ (small for gestational age)

LGA? _____ (large for gestational age)

What was your child's Apgar score? _____

Describe any problems at birth e.g., respiratory distress, congenital birth defects:_____

_____

_____

Describe all medical conditions, medications given or special medical treatments following birth:_____

_____

Other Conditions:

_____ Prematurity
_____ Meconium Aspirations
_____ Placenta Previa
_____ Meningitis
_____ Bronchopulmonary Dysplasis (BPD)
_____ Hemorrhage or bleeding
_____ Neonatal Seizures
_____ Jaundice: Treatment given:

_____

_____ Cytomegalovirus (CMV)
_____ Asphyxia (Oxygen Deprivation)
_____ Rh Incompatibility
_____ Cleft lip and/or palate
_____ Congenital birth defects
_____ Other physical abnormalities
_____ Eclampsia
_____ Toxemia

Hospitalized in: _____regular nursery _____special care nursery

Length of stay: _____regular nursery _____special care nursery

Required transfer to another hospital:_____

Reason for extended hospital stay:_____

_____

_____

IV. EARLY INFANCY

Describe ability to suck, swallow or chew (where applicable):

_____alert _____easy comforted

_____aware of light _____lethargic

_____aware of sound _____difficult to comfort

_____colicky

Developmental History

Age at which the following occurred:

Showed response to mother	_____	Raised Head	_____
Sat without support	_____	Crawled	_____
Cut first tooth	_____	Stood alone	_____
Walked alone	_____	Toilet training	_____
Ate solid foods	_____	Drank from cup	_____

Feeding History

_____Bottle fed: formula_____ milk_____

_____Bottle fed/Breast fed with supplement_____

_____NG tube feeding; reason for placement:_____

_____G-tube feeding; reason for placement:_____

_____Self-feeding; age began_____

Began solid foods at age_____

Current food types taken:_____

Currently, child: _____drinks from cup _____finger feeds _____uses utensils

Does child exhibit coughing, choking, drooling, etc. when eating? Describe:_____

_____

Describe any feeding and/or nutritional concerns you may have:_____

_____

Has your child's feeding and/or nutrition ever been evaluated?_____

V. COMMUNICATION DEVELOPMENT

List the ages at which your child demonstrated the following:

Responded to sounds in the environment _____
Startled or cried at loud noises _____
Searched for source of voice/sound _____
Responded differentially to environmental sounds _____
Social smiles _____
Cooed and babbled _____
Comprehended speech of others _____
First words _____
Example of first words_____
Combined words _____
Requested objects/people by name _____
Used 2 or 3 word phrases _____
Used complete sentences _____
Related daily activities (reported past events) _____

What percentage of child's speech can mother understand?

All_____ Most_____ Some_____ Very little_____

What percentage of child's speech can other adults understand?

All_____ Most_____ Some_____ Very little_____

Describe what parents have done to help child with his/her communication:_____

_____

_____

Describe any stuttering-like behavior demonstrated by your child:_____

_____

_____

Does your child's voice sound like other children's voices? If not, describe:_____

_____

_____

VI. THERAPY AND SCHOOL HISTORY

Has your child ever been seen by a Speech/language Pathologist for evaluation and/or treatment? Please discuss; include names, dates and reason:_____

_____

Describe any frustration or anxiety demonstrated by your child due to communication problems:_____

Has/is your child received/receiving other special services: Please list provider, location and dates.

Occupational Therapist_____

Physical Therapist_____

Educational Services_____

Developmental Assessment_____

Feeding Swallowing Evaluation_____

Neurologist_____

Audiologist_____

Counseling_____

Other_____

Name/location of school now attending:_____

_____Grade level_____

Teacher_____Speech/Language Pathologist_____

Hearing/Vision

Describe any hearing problems past or present:_____

_____

Does hearing vary? Describe:_____

Has your child's hearing ever been tested?_____Where?_____Date_____

Results:_____

(If possible, attach a copy of audiogram)

Describe any ear infections your child has had, including dates, severity, treatment, medications and surgery:_____

_____

How did you know about the ear infections?_____

Does your child currently have tubes in his/her ears?_____

If so, when were they inserted?_____

Does your child wear a hearing aid?_____Type and Model_____

If hearing impaired, does your child sign?_____

Describe any vision problems, past or present:_____

Does your child wear glasses?_____If yes, how long?_____

VII. MEDICAL HISTORY

Child's present state of health:_____

Name/address of Physician:_____

_____

Describe any illness, accidents, allergies or hospitalizations:_____

_____

Describe any current medical problems and treatment:_____

_____

List any regularly prescribed medications:

Name:_____ Reason:_____

_____ _____

_____ _____

VIII. SOCIAL/BEHAVIORAL HISTORY

Describe your child's typical day:_____

_____

_____

_____

Describe your child's play, interests and activities:_____

_____

_____

Does your child prefer to play alone or with others?_____

Does your child exhibit any sleep difficulties?_____

Does your child take regular naps?_____

Describe any behavioral/emotional problems:_____

_____

Describe how speech/language/hearing problems appear to affect your child's interaction with other children:_____

_____

Is there any additional information that may help us understand your child better?_____

_____

_____

_____

_____