Blue Roots Speech & Language

CASE HISTORY FORM

Child's Name: _____ Birthdate: _____ Sex. ☐ M ☐ F

Father's Name: _____ Daytime Phone: _____
Address: _____ Cell Phone: _____
_____ Email: _____
Occupation: _____

Mother's Name: _____ Daytime Phone: _____
Address: _____ Cell Phone: _____
_____ Email: _____
Occupation: _____

Physician's Name: _____ Physician's Phone: _____

Family History

Child resides with (Check one):

☐ Birth Parents ☐ Foster Parents ☐ One Parent
☐ Adoptive Parents ☐ Parent & Step-parent ☐ Other: _____

Siblings in the household:

Name	Age	Sex	Grade Level	Speech/hearing complications
1.				
2.				
3.				
4.				

Child's race/ethnic group:

☐ Caucasian, Non-Latino ☐ Latino/Latina ☐ African-American
☐ Native American ☐ Asian or Pacific Islander ☐ Other: _____

What is the primary language spoken in the home? _____
What other languages are spoken in the home? _____

If your child is in a multilingual household, please answer the following questions:

What languages does your child speak? _____

What languages does your child understand? _____

Which language does the child speak the majority of the time in the home? _____
_____

Speech-Language

Briefly describe why you are seeking an evaluation by a Speech-Language Pathologist (SLP) at this time:

_____

_____

_____

If anyone else in the family has a speech or language diagnosis, please describe:

_____

_____

_____

Has your child had a previous speech-language evaluation, screening, and/or treatment?

☐ Yes ☐ No

If yes, where and when? _____

Describe the results? _____

_____

_____

Do you feel your child has hearing complications? ☐ Yes ☐ No

If yes, please describe: _____

_____

_____

Has your child ever had a hearing evaluation/screening? ☐ Yes ☐ No

If yes, where and when? _____

What were the results? _____

_____

_____

Has your child received any other evaluation or therapy (physical therapy, counseling, occupational therapy, vision, etc.)? ☐ Yes ☐ No

If yes, please describe: _____

_____

_____

_____

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? _____

_____

Birth History

Were there any complications with the pregnancy or birth? ☐ Yes ☐ No

If yes, please describe. _____

_____

_____

How many weeks gestation was the child born? _____

What was the child's birth weight? _____

How was the child delivered? ☐ Vaginally ☐ Cesarean Section

What was the mother's age at the time of delivery? _____

Did the child go home with his/her mother from the hospital? ☐ Yes ☐ No

If child stayed at the hospital, please describe why and how long. _____

_____

_____

Medical history

Has your child had any of the following?

- ☐ Adenoidectomy
- ☐ Allergies
- ☐ Asthma
- ☐ Behavior Problems
- ☐ Chicken pox
- ☐ Hand, foot, and mouth
- ☐ Ear infections
  How often? _____
- ☐ Ear tubes
- ☐ Encephalitis
- ☐ Flu
- ☐ Head injury
- ☐ High fevers
- ☐ Measles
- ☐ Meningitis
- ☐ Mumps
- ☐ Scarlet fever
- ☐ Seizures
- ☐ Sensory Issues
- ☐ Sinusitis
- ☐ Sleeping difficulties
- ☐ Thumb/finger sucking
- ☐ Tongue Tie
- ☐ Tonsillectomy
- ☐ Tonsillitis
- ☐ Vision problems

Please elaborate on any of the boxes you have checked:

_____

_____

_____

Other serious injury/surgery: _____

Is your child currently (or recently) under a physician's care? ☐ Yes ☐ No

If yes, why? _____

_____

Please list any medications your child takes regularly: _____

_____

_____

Is your child up to date with immunizations? ☐ Yes ☐ No

If no, please describe: _____

_____

Does your child have any known allergies? ☐ Yes ☐ No

If yes, please describe: _____

_____

Developmental History

Please tell the approximate age your child achieved the following developmental milestones:

_____ Sat alone
_____ Stood Up
_____ Babbled
_____ Combined Words
_____ Fed Self
_____ Toilet Trained

_____ Crawled
_____ Walked
_____ First Word
_____ Spoke in short phrases
_____ Dressed Self

Does your child:

☐ Choke on food or liquids?
☐ Avoid Foods
☐ Use a Pacifier/Suck Thumb
☐ Choke on Foods
☐ Maintain a special diet
☐ Currently put toys/objects in his/her mouth?

Current Speech-Language

Does your child…

☐ repeat sounds, words or phrases over and over?
☐ understands what you are saying?
☐ retrieve/point to common objects upon request (chair, car, apple)?
☐ follow directions (“Put your toys away” or “Get your ball”)
☐ respond correctly to yes/no questions?
☐ respond correctly to who/what/where/when/why questions?
☐ have difficulty producing sounds?
☐ engage in turn-taking conversation (asking questions/making comments)?

Your child currently communicates using…

☐ Body language.
☐ Sounds (vowels, grunting, etc.).
☐ Words (shoe, doggy, up).
☐ 2 - 4 word phrases.
☐ Sentences longer than four words.
☐ Other _____.

Behavioral characteristics:

- ☐ Cooperative
- ☐ Attentive
- ☐ Willing to try new activities
- ☐ Plays alone for reasonable length of time
- ☐ Separation difficulties
- ☐ Easily frustrated/impulsive
- ☐ Stubborn
- ☐ Restless
- ☐ Poor eye contact
- ☐ Easily distracted/short attention span
- ☐ Destructive/aggressive
- ☐ Withdrawn
- ☐ Inappropriate behavior
- ☐ Self-abusive behavior

Educational History

Is your child currently enrolled in daycare/school? ☐ Yes ☐ No

What is the name of the school/program? _____

What days/time does your child attend? _____

Grade level? _____

Please describe any educational difficulties or learning challenges that this child has faced: _____
_____

Please describe any accommodations that are implemented in the classroom: _____
_____
_____

Social History:

Please describe how your child interacts with parents, siblings, or other family members: _____
_____
_____

What are your child's strengths? _____
_____

What are your child's weaknesses? _____
_____

What are your child's interests/favorite activities? _____
_____

What are your main goals for your child? _____
_____

Additional Comments

Thank you! Blue Roots Speech & Language looks forward to working with you and your child.