

CHILD/ADOLESCENT CASE HISTORY FORM

To assist us with learning more about your child's communication skills, please complete the following form. Write NA in the questions that do not apply to your child.

INTRODUCTION

Child's Name _____ Birthdate _____ Sex _____

What are your concerns about your child's communication?

What do you want to know when we're done?

What does your child do well?

What does your child need help doing?

Describe your child's favorite activities:

BACKGROUND INFORMATION

Parents' Names: _____

Address: _____ City: _____ State: _____ Zip: _____

County: _____ Email: _____

Home Phone: _____ Cell Phone: _____

Mother's Work Phone: _____ Father's Work Phone: _____

School: _____ School District: _____ Grade: _____

Teacher's Name: _____

School Address: _____ City _____, State _____ Zip: _____

Languages spoken in the home: _____ Primary Language: _____

Name of person completing this form: _____

Relationship to child: _____

Physician's name: _____ Physician's phone number: _____

Who referred you to this clinic? _____

Has the child been diagnosed with any of these? intellectual disability ____ cerebral palsy ____

down syndrome ____ chronic middle ear infections ____ learning disability ____

attention deficit disorder ____ attention deficit hyperactivity disorder ____ down syndrome ____

central auditory processing disorder ____ cleft lip or palate ____ emotional disability ____

developmental delay ____ autism spectrum disorder ____

If you checked any of these, please tell when _____ and who made the diagnosis

_____.

Does the child have any other diagnoses including medical diagnoses? _____

If so, please describe.

BIRTH HISTORY

Describe the child's birth. Report any unusual conditions.

COMMUNICATION DEVELOPMENT

Did the child make sounds during infancy? _____ At approximately what age? _____

With or without you talking to him/her? _____ Age of first words _____

Age at which child put two words together (Ex. "Want cookie.") _____ Age at which child put three words together (Ex. "Mommy go bye-bye.") _____ Did the child talk little or much? _____

Describe: _____

Any periods when the child quit talking? _____ Describe _____

Does the child have any trouble pronouncing words? _____ Does the child have difficulty understanding what is said? _____

Does the child have difficulty expressing her/himself verbally? _____

If yes, describe. _____

Has there been previous speech/language testing? _____ If yes, by whom? _____

When? _____ Where? _____

Results: _____

Have there been any relatives with speech/language problems? _____ If yes, please state relationship(s) and describe the problems _____

MOTOR DEVELOPMENT

Age of holding head up: _____ Age of sitting up: _____

Age of first steps alone: _____ Describe Coordination: _____

MEDICAL HISTORY

VISION

Date of last vision examination? _____

Results? _____

Describe any history with vision problems.

Describe any history with glasses (age they were prescribed. When are glasses worn?)

HEARING

Date of last hearing examination? _____

Results? _____

Describe any history with ear infections (ages, medications, PE tubes, etc.)

_____ Describe any history with hearing aids/ cochlear implants (ages, which ear/s, types of aid, etc.)

SEIZURES

If the child has had any seizures, please explain: (Dates, all medications, results, current status)

If the child has a history of fainting spells, please explain: (Dates, situation, medical tests, results, current status)

ALLERGIES

Please list all known allergies:

Please describe immediate action to be taken in case of contact with allergen (s):

GENERAL MEDICAL

Age of bladder control during the day _____ During the night _____

Describe any sleeping problems.

SCHOOL HISTORY

Child's grade level: _____

Describe your child's strengths at school:

Check any areas that are problems at school, then elaborate in the space below:

Subjects: Reading ____ Writing ____ Spelling ____ Math ____ Content areas (e.g., history) _____

Skills: Paying attention ____ expressing him/herself ____ memory ____ getting along with peers ____
working independently ____ other things you notice (please describe) _____

Does your child receive any of the following supports?

Special education (specify the reason)

Resource room (describe)

Tutoring (describe)

Observations:

What do teachers say?

What do you notice?

Describe any changes over time:

How are your child's grades?

SOCIAL AND HOME ENVIRONMENT

Home environment:

Who lives with the child now?

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Who else does the child regularly spend time with?

Name: _____ Relationship: _____

Child's race/ethnic group: Caucasian _____ non-Hispanic _____ Hispanic _____

African American _____ Native American _____ Asian or Pacific Islander _____ Other _____

Describe any learning/developmental/social/medical problems in the family: _____

Social:

Does your child have friends? Many? _____ A few _____ Very few _____

Does your child mostly socialize with children: his own age? _____ Younger? _____ Older? _____

What is the child's attitude toward the speech problem? _____

What is the attitude of the family & friends towards the child's speech problems? _____

ADDITIONAL QUESTIONS OR COMMENTS:

