SeaGlass speech therapy

Child Case History Form

1. Identification

Name:

Date of Birth: Age: ☐ Male ☐ Female

Address:

City:

State: Zip:

Referred By:

Address:

City:

State: Zip:

Reason:

Physician: Phone:

Other Doctors (dentists/orthodontists/psychologists etc.) that provide care to this child:

Name:

Specialty: City:

Name:

Specialty: City:

Name:

Specialty: City:

2. Family

Mother:

Age: Occupation:

Email: Phone:

History of speech, language, or hearing problems? ☐ Yes ☐ No

If yes, please explain:

Father:

Age: Occupation:

Email: Phone:

History of speech, language, or hearing problems? ☐ Yes ☐ No

If yes, please explain:

Names of brothers/sisters: Age:

Is there a family history of any of the following?

	Family member:
Hearing loss	
Speech problem	
Prematurity	
Blindness	
Malformation of the head, neck, or ears	
Educational difficulties	
Drug use	
Cleft palate	
Seizure disorder	
Mental illness	
Alcoholism	
Delayed motor development	
Low birth weight	
Other:_____	

Does the child live with both parents? ☐ Yes ☐ No

If no, whom does the child live with?

Have there been any of the following major changes in the family during the last year?

☐ Change of Address ☐ Accident or Illness ☐ Divorce/Marriage

☐ Parent Separation ☐ Death of Family Member ☐ Birth/Adoption

Does anyone in the home smoke? ☐ Yes ☐ No

3. Birth History

Mother's health during pregnancy (note special conditions such as mumps, German measles, x-rays, serious accidents, etc.)

Anything unusual about the condition of the infant at birth?

☐ Blue Baby ☐ Lack of Oxygen ☐ Convulsions

☐ Rh Problems ☐ Breathing Difficulties ☐ Head Injuries

Other (please describe)

Length of pregnancy: ☐ weeks Birth weight: ☐ lbs ☐ oz

4. Developmental History

Has your child had any feeding difficulties? Check each that applies:

☐ Sucking or nursing ☐ Difficulty chewing or swallowing meats

☐ Excessive length of time to drink bottle ☐ Gagging

☐ Regurgitation of liquids or solids through the nose ☐ Choking

Which foods does your child gag/choke on, if any?

Is your child a picky eater? ☐ Yes ☐ No

If yes, what foods does he/she prefer?

Describe any feeding problems your baby experienced during the first three months of life:

Does your child excessively drool? ☐ Yes ☐ No

Did your baby have difficulty gaining weight? ☐ Yes ☐ No

Describe any early abnormalities of response to light, sound, and movement:

At approximately what age did your child achieve the following motor milestones?

Head support		Reach & grasp	
Sitting alone		Crawling	
Standing alone		Walking alone	
Climbing stairs		Finger food	
Eat with a spoon		Potty trained	
Undresses self			

Do you consider your child's coordination normal? ☐ Yes ☐ No

Your child is ☐ Right handed ☐ Left handed

At what age did handedness develop?

Did anyone try to influence handedness? Please describe:

Were there any abnormalities in early physical development?

5. Medical History

Check any childhood illnesses and injuries. In the box below, list illness, age, amount of fever, and after-effects, if any.

☐ Ear aches	☐ Ear-drainage	☐ Pneumonia
☐ Convulsions	☐ Measles	☐ Chickenpox
☐ Frequent colds	☐ Bronchitis	☐ Allergies (describe below)
☐ Asthma	☐ Enlarged adenoids	☐ Tonsillitis
☐ Concussions	☐ Serious Injuries	☐ Operations (describe below)
☐ Other (describe below)		

List any medication your child is currently taking:

Explain your child's present health:

Has the child had an eye examination? ☐ Yes ☐ No

If yes, when?

6. Play Behaviours

Which of the following describes the type of play your child likes to engage in the most often?

☐ Putting toys in mouth	☐ Banging toys together	☐ Throwing toys
☐ Shaking toys	☐ Pushing/pulling toys	☐ Appropriate use of objects
☐ Uses one object for another	☐ Acting out familiar routines	☐ Role playing
☐ Make believe play	☐ Games with rules	☐ Rough and tumble play
☐ Looking at books		

Does your child seem inattentive while playing with toys or doing certain activities?

☐ Yes ☐ No

If yes, please explain:

Whom does your child prefer to play with?

7. Personality

What are your child's chief interests?

Does your child display any unusual behaviors or behavioral problems?

Describe any discipline problems you have with your child:

What problems does the child have in school, if any?

8. Educational History

PRESCHOOL AGE

Child care facility name:

How often does your child attend?

Have teachers expressed any concerns about your child's learning behavior?

☐ Yes ☐ No

If yes, please describe:

SCHOOL AGE

School name: Grade:

9. Speech History

What languages are spoken at home?

Which are spoken by the child?

Which are understood by the child?

Indicate when your child first demonstrated the following:

Cooing sounds Babbling

Made up language Single words

Phrases (go bye-bye) Short sentences

What is the primary method(s) your child uses for letting you know what he/she wants?

☐ Looking at objects ☐ Pointing at objects ☐ Gestures

☐ Crying ☐ Vocalizing/grunting ☐ Physical manipulation

☐ Single words ☐ 2-3 word combinations ☐ Sentences

Which of the following best describes your child's speech?

- ☐ Easy to understand
- ☐ Difficult for parents to understand
- ☐ Difficult for others to understand
- ☐ Almost never understood by others
- ☐ Different than other children of the same age

Which of the following best describes your child's reaction to his/her speech?

- ☐ Is easily frustrated when not understood
- ☐ Does not seem aware of speech/communication problems
- ☐ Has been teased about his/her speech
- ☐ Tries to say sounds or words more clear
- ☐ Is successful in saying sounds or words more clearly when he/she tries

List any sounds your child has difficulty producing:

Does your child hesitate and/or repeat sounds or words? ☐ Yes ☐ No

Do you have concerns about your child's voice? ☐ Yes ☐ No

Describe when the speech difficulty was first noticed, and by whom:

Describe any changes you have noticed in your child's speech since the difficulty was first noticed:

10. Hearing

Describe any hearing difficulties or concerns:

Has the child had their hearing tested? ☐ Yes ☐ No

If yes, when?

11. Previous Speech Treatment

Has your child ever received speech treatment? ☐ Yes ☐ No

For how long?

Describe the results of the previous speech treatment:

12. Statement of Problem

Please state in your own words what you think the child's problem is, and what you think might have caused it:

When did you first notice the problem?

What information do you hope to gain from this evaluation, and what specific questions or areas do you wish to address?

Form completed by: _____ (print name)

Date: _____

Signed: _____

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