

Child Case History Form

The following information is for professional use and will be handled confidentially. This information will assist the speech language pathologist in completing your child's evaluation.

Please complete the following questions as fully and accurately as possible. If you are unable to complete a question, please leave it blank or you may call our office for assistance at (773)517-7669

General Information

Name of person completing this form _____

Relationship to this child _____ Date completed _____

Child's Name _____
Last First Middle

Nickname (s) _____ Date of Birth _____ Age _____ Sex: Male ___ Female ___

Sibling Information

Name _____ Age _____ Male ___ Female ___

Name _____ Age _____ Male ___ Female ___

Name _____ Age _____ Male ___ Female ___

Primary Language _____ Language spoken in the home _____

What language does the child speak? _____

Please indicate your primary concern about your child's speech and language skills: _____

Medical History

Please indicate if the child has experienced any of the following conditions:

Allergies	Yes ___ Explain _____
Autism	Yes ___ Explain _____
Attention Deficit Disorder	Yes ___ Explain _____
Asthma	Yes ___ Explain _____
Chicken Pox	Yes ___ Explain _____
Epilepsy	Yes ___ Explain _____
Seizures	Yes ___ Explain _____
High Fevers	Yes ___ Explain _____
Meningitis	Yes ___ Explain _____

Muscular Disease Yes ___ Explain _____
Traumatic Brain Injury Yes ___ Explain _____
Vision Problems Yes ___ Explain _____
Other _____

Child's Primary Care Physician: _____

Has your child had an audiological evaluation (hearing test)? Yes ___ No ___ When _____

Where _____

Were the results normal? Yes ___ No ___. If no, please explain _____

Occurrence of ear infections Yes ___ If "yes", approximately how many ear infections to date _____

Last date of ear infection _____ Please explain course of treatment _____

Has your child had any speech and language testing? Yes ___ No ___, If, "yes", Where? _____

Has your child had any Speech and Language Intervention: Yes ___ No ___ if "yes",

Where? _____

List any medications prescribed for your child _____

If your child has had other significant medical treatment your, please explain _____

Developmental History

Prenatal and Birth History

Length of pregnancy _____ Delivery Complications Yes ___ No ___ Birth weight _____

(Please explain if any complications occurred) _____

Did the infant have any difficulty with breathing, crying, sucking, jaundice, convulsions, blood incompatibility, etc. (Please explain) _____

A. Motor Milestones

Please indicate the age or approximate age at which the following occurred:

Crawled _____ Sat alone _____ Walked unaided _____ Fed self _____ Dressed self _____
Toilet trained _____ Cooing _____ Babbling _____ First words _____

Vocabulary of approximately 50 words: Understood _____ Expressed _____

Two-word combinations _____ (examples: *more milk, me do, no go*)

Short Sentences _____ (examples: *Me want juice., Mommy do it.*)

B. Receptive and Expressive Language Skills

Please answer “yes” or “no” or “sometimes” to the following questions:

1. Does your child respond to his/her name? Yes ___ No ___ Sometimes ___
2. Will your child get common objects when asked? Yes ___ No ___ Sometimes ___
3. Does your child follow simple directions? Yes ___ No ___ Sometimes ___
4. Will your child point to pictures as you name them? Yes ___ No ___ Sometimes ___
5. Does your child label pictures? Yes ___ No ___ Sometimes ___
6. Does your child ask questions? Yes ___ No ___ Sometimes ___ (Please give Examples) _____

7. Does your child repeat or “echo” others’ expressions? Yes ___ No ___ Sometimes ___
8. Does your child repeat questions or parts of questions rather than answering them? Yes ___ No ___ Sometimes ___
9. Does your child **excessively** recite/repeat words from video tapes/DVDs, songs, or television programs? Yes ___ No ___ Sometimes ___
10. Has your child said a word and few times, then never used it again? Yes ___ No ___ Sometimes ___ If “yes”, when? _____ What words? _____

11. Did language development seem to just stop? Yes ___ No ___ Sometimes ___ If “yes”, when? _____

How does your child indicate his/her needs/wants to you? _____

How does your child indicate he/she does **not** want something or does not want to do something?

What types of words/sentences does your child express independently? _____

Behavioral Information

A. Infancy

Was a silent infant? Yes ___ No ___ Sometimes ___

Was an inconsolable infant? Yes ___ No ___ Sometimes ___

Very happy infant (rarely cried, did not desire interaction/affection)? Yes ___ No ___
Sometimes ___

Other comments _____

B. Play

Prefers to play alone? Yes ___ No ___ Sometimes ___

Plays poorly with other children or does not interact with others? Yes ___ No ___
Sometimes ___

Frequently lines items in a row? Yes ___ No ___ Sometimes ___

Protests if line is interrupted? Yes ___ No ___ Sometimes ___

Holds (clutches) items for extended periods of time? Yes ___ No ___ Sometimes ___

Frequently counts (objects, items, actions etc) Yes ___ No ___ Sometimes ___

Has unusual interest (strips of paper, electrical cords etc.)? Yes ___ No ___ Sometimes ___

Spins objects? Yes ___ No ___ Sometimes ___

Other comments _____

C. Conduct

Is difficult to manage? Yes ___ No ___ Sometimes ___

Has a behavior problem? Yes ___ No ___ Sometimes ___

Displays temper tantrums? Yes ___ No ___ Sometimes ___

Consistently has a catastrophic reaction when told "no"? Yes ___ No ___ Sometimes ___

Discipline is ineffective? Yes ___ No ___ Sometimes ___

Is overly active? Yes ___ No ___ Sometimes ___

Has a short attention span? Yes ___ No ___ Sometimes ___

Is aggressive towards self? Yes ___ No ___ Sometimes ___

Is aggressive towards others? Yes ___ No ___ Sometimes ___

Is destructive with objects? Yes ___ No ___ Sometimes ___

Other comments _____

A. General

Is withdrawn? Yes ___ No ___ Sometimes ___

Rocks back and forth? Yes ___ No ___ Sometimes ___

Acts as if deaf? Yes ___ No ___ Sometimes ___

Covers ears with hands? Yes ___ No ___ Sometimes ___

Has limited eye contact? Yes ___ No ___ Sometimes ___

Has difficulty with change/transitions? Yes ___ No ___ Sometimes ___

Other comments _____

B. Fears

Climbs without fear? Yes ____ No ____ Sometimes ____

Has unusual fears (specific animals, places, noises, etc.)? Yes ____ No ____ Sometimes ____

Exhibits age appropriate fears (separation, being lost, darkness, etc)? Yes ____ No ____
Sometimes ____

Other Comments _____

Educational History

Please indicate any of the following that apply:

Early intervention program (s) _____

Daycare/Preschool: _____

Schools attended: _____

Special Programs: _____

Other: _____

Please Describe your child's personality: _____

Please feel free to indicate any questions or concerns that you would like to specifically discuss at your initial appointment.

1. _____

2. _____

3. _____

4. _____

5. _____