SPEECH AND LANGUAGE CASE HISTORY FORM

Date _____
Person filling out this questionnaire_____
Relationship to child_____

IDENTIFYING INFORMATION

Child's Name_____ DOB_____
Child's Age_____ M_____ F_____
Address_____ City_____
County_____ State____ Zip_____

FAMILY INFORMATION

Parent/Guardian_____ Age___ Occupation_____
Address_____Phone#_____
Parent/Guardian_____ Age___ Occupation_____
Address_____Phone#_____

OTHER CHILDREN IN THE FAMILY

NAME	SEX	AGE	GRADE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Whom can we thank for telling you about our practice? _____

STATEMENT OF THE PROBLEM

Describe as best you can the problem that you have noticed with your child's speech and language. Please also note when the problem was first noticed.

_____
_____
_____

List any other concerns that you have about your child's development.

_____
_____
_____

Are there any skills that your child previously had but can no longer use?

_____
_____
_____

Has your child's hearing been tested? _____yes _____no
If so, where and when was the test completed? _____
Results of the hearing test _____normal _____hearing loss _____further testing required

Have any other family members had speech, language, or hearing problems or learning difficulties? If yes, who? _____ please describe: _____
_____
_____

What languages are spoken in the home? _____
What is the primary language used with this child? _____

CHILD'S MEDICAL HISTORY

Name of Child's Physician: _____Medical Office:_____

Describe the mother's health during pregnancy: □ Good □ Fair □ Poor

Were there any unusual conditions or problems during the pregnancy or birth? □ No □ Yes If yes, please describe:
Were there any drugs or alcohol consumed during the pregnancy? □ No □ Yes If yes, what and how often?
Was the pregnancy full term? □Yes □No If no, how early or late?

General condition: _____ Birth weight:
Does your child have any medically diagnosed illness or conditions? □Yes □ No If yes, please explain:
Is your child taking any medications? □Yes □No If yes, please list:
Has your child experienced any of the following? □ Frequent Colds □ Seizures □ Snoring □ Mouth Breathing □ Sleeping Problems □ Frequent Ear Infections □ Other:
Has your child had any surgeries, accidents or hospitalizations? □ No □ Yes If yes, please explain:
Are there or have there ever been any feeding problems (e.g., problems with sucking, swallowing, drooling, chewing, etc.)? □ No □ Yes If yes, please explain:
Is there anything else we should know about your child's medical history? □ Yes □ No If yes, please explain:
Has your child had any of the following evaluations or assessments? Please indicate: □ Hearing □Speech and Language □Psychological □Physical Therapy □ Neurological □Occupational Therapy □Developmental □Vision
What were the results?
Has your child received any of the following services? □ Speech/Language □ OT □ PT □ Nursing

Developmental History: Please provide the approximate age at which the child acquired the following skills. If you can't remember the age, check the box that best describes when he/she acquired the skill as compared to his/her peers.

Activity	Age	Same as Peers	Earlier than Peers	Later than Peers
Sit				
Crawl				
Walk				
Feed Self				
Dress Self				
Toilet Trained				

Speech & Language History: Please provide the approximate age at which the child acquired the following skills. If you can't remember the age, check the box that best describes when he/she acquired the skill as compared to his/her peers.

Activity	Age	Same as Peers	Earlier than Peers	Later than Peers
Babbling				
Use first word				
Put 2-3 words together				
Make sentences				
Put sentences together				
Engage in conversation				
Understand conversation				

Does your child talk a lot_____ occasionally_____ never_____
prefer gestures over words_____
Does your child speak in words_____2 word sentences____ 3 word sentences_____
Does your child hesitate or stutter on words _____yes _____no
How well is your child understood by the following? (A for always S for sometimes N for never) parents_____ siblings_____ extended family_____ friends_____
teacher_____ strangers_____
Does your child respond to his/her name being called _____yes _____no
Does your child make eye contact when speaking or being spoken to _____yes
_____no
Is your child able to follow 1 step directions _____ 2 step directions_____3 step directions_____
Does your child appear to understand what is being said to him/her _____yes
_____no

FAMILY HISTORY Are there any members of your immediate family that have been diagnosed with any of the following: (Please indicate "F" for father, "M" for mother, or "S" for sibling)

learning disability _____
dyslexia _____
speech and language delay/disorder _____
sensory processing disorder _____
auditory processing disorder _____
ADD/ADHD _____

autistic spectrum disorder/PDD_____
other, please explain _____

Additional Information

What are your child's strength's?

_____
_____
_____
_____

What type of activities interest your child?

_____
_____
_____
_____

Please list any food allergies:

_____
_____
_____
_____

Is there a teacher or caregiver who we may contact to gather further information about your child? If yes, please identify:
Name: _____ Position: _____
Telephone:

Name: _____ Position: _____
Telephone:

Name: _____ Position: _____
Telephone:

I authorize Three C's Therapy Services staff to contact the above person(s), as needed for the purpose of gathering information for my child's evaluation.

_____
Signature of Parent/Guardian

I authorize Three C's Therapy Services to give my child food and/or candy that may be used as a part of therapy and/or as a treat.

_____

Signature of Parent/Guardian

I authorize three C's Therapy Services to take pictures of my child to be used on the website, brochures or other marketing materials.

_____

Signature of Parent/Guardian