

Child Case History

Speech Therapy Department

Family Information:

Child's Name: _____

Sex: M / F

Father's Name: _____

Daytime Phone: _____

Address: _____

Cell Phone: _____

E-mail: _____

Mother's Name: _____

Daytime Phone: _____

Address: _____

Cell Phone: _____

E-mail: _____

Doctor's Name: _____

Doctor's Phone: _____

Birth date: _____

Child lives with (check one):

- | | | |
|---|---|--------------------------------------|
| <input type="checkbox"/> Birth Parents | <input type="checkbox"/> Foster Parents | <input type="checkbox"/> One Parent |
| <input type="checkbox"/> Adoptive Parents | <input type="checkbox"/> Parent and Step-Parent | <input type="checkbox"/> Other _____ |

Other children in the family:

Name	Age	Sex	Grade	Speech/Hearing Problems
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Are there any other speech, language or hearing problems in your family? If so, please explain:

Child's race/ethnic group: _____

What languages are spoken at home? _____

Who speaks them in your family? _____

Which are spoken by your child? _____

Which are understood by your child? _____

Which language does your child prefer to speak at home? _____

What percentage of English is spoken by your child? _____

When was your child first exposed to English? _____

Speech-Language-Hearing:

Do you feel your child has a speech problem? Y / N

If yes, please describe.

Do you feel your child has a hearing problem? Y / N

If yes, please describe.

Has your child ever had a speech evaluation/screening? Y / N

If yes, please describe.

Has your child ever had a hearing evaluation/screening? Y / N

If yes, please describe.

Has your child ever had speech therapy? Y / N

If yes, where and when? _____

What was he/she working on? _____

Has your child received any other evaluation or therapy (physical therapy, counseling, occupational therapy, vision, etc.)? Y / N

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? _____

Educational History:**Preschool Age:**

Educational Setting: Child Care Facility Early Childhood Classes
 Birth to 3 Program Home

How often does your child attend classes?

daily 4 times per week 3 times per week
 2 times per week ½ days full day

Does your child's developmental performance seem to interfere with his/her school performance? Yes No

Have teachers expressed any concerns about your child's learning behavior?
 Yes No

If so please describe.

School Age:

Name of School: _____ Grade: _____

Teacher's Name: _____

Has your child repeated a grade?: Y / N Reason: _____

What are your child's strengths and/or best subjects? _____

Is your child having difficulty with any subjects? _____

Is your child receiving help in any subjects? _____

Birth History:

Was there anything unusual about the pregnancy or birth? Y / N

If yes, please describe: _____

How old was the mother when the child was born? _____

Was the mother sick during the pregnancy? Y / N

If yes, please describe: _____

Length of pregnancy? _____

Did the child go home with his/her mother from the hospital? Y / N

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

Medical History:

Has your child had any of the following?

- | | | |
|---|--|---|
| <input type="checkbox"/> adenoidectomy | <input type="checkbox"/> flu | <input type="checkbox"/> seizures |
| <input type="checkbox"/> allergies | <input type="checkbox"/> gastrointestinal problems | <input type="checkbox"/> sinusitis |
| <input type="checkbox"/> breathing difficulties | <input type="checkbox"/> head injury | <input type="checkbox"/> sleeping difficulties |
| <input type="checkbox"/> chicken pox | <input type="checkbox"/> high fevers | <input type="checkbox"/> thumb/finger sucking habit |
| <input type="checkbox"/> colds | <input type="checkbox"/> measles | <input type="checkbox"/> tongue-tied |
| <input type="checkbox"/> dental problems | <input type="checkbox"/> meningitis | <input type="checkbox"/> Clipped? Y / N |
| <input type="checkbox"/> ear infections | <input type="checkbox"/> mumps | <input type="checkbox"/> tonsillectomy |
| How often?
_____ | <input type="checkbox"/> respiratory problems | <input type="checkbox"/> tonsillitis |
| <input type="checkbox"/> ear tubes | <input type="checkbox"/> scarlet fever | <input type="checkbox"/> vision problems |
| <input type="checkbox"/> encephalitis | | |

Other serious injuries/surgeries: _____

Is your child currently (or recently) under a physician's care? Y / N

If yes, why? _____

Please list any medications your child takes regularly: _____

Developmental History:
Please indicate the approximate age your child achieved the following developmental milestones:

- | | |
|-----------------------------|------------------------------|
| _____ sat alone | _____ babbled |
| _____ crawled | _____ said first words |
| _____ stood | _____ used requests |
| _____ walked | _____ used labels |
| _____ fed self | _____ put two words together |
| _____ dressed self | _____ named simple objects |
| _____ used toilet | _____ used simple sentences |
| _____ grasped crayon/pencil | |

Does your child do any of the following?

- have difficulty sucking? _____
- have difficulty chewing? _____
- have difficulty swallowing? _____
- choke on food or liquids? _____
- picky eater with certain textures and/or foods? _____
- drool? _____
- currently put toys/objects in his/her mouth? _____
- brush his/her teeth and/or allow brushing? _____

Current Speech-Language-Hearing

Your child currently communicates using (check all that apply)...

- body language/gestures
- crying
- sounds (vowels, grunting)
- single words
- physical manipulation
- 2 to 4 word sentences
- sentences longer than 4 words
- other _____

Does your child (check all that apply)...

- repeat sounds, words or phrases over and over?
- understand what you are saying?
- retrieve/point to common objects upon request (ball, cup, shoe)?
- follow simple directions (“shut the door” or “get your shoes”)?
- respond correctly to yes/no questions?
- respond correctly to who/what/where/when/why questions

Behavioral Characteristics (check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> cooperative | <input type="checkbox"/> restless |
| <input type="checkbox"/> attentive | <input type="checkbox"/> poor eye contact |
| <input type="checkbox"/> willing to try new activities | <input type="checkbox"/> easily distracted/short attention |
| <input type="checkbox"/> plays alone for a reasonable amount of time | <input type="checkbox"/> destructive/aggressive |
| <input type="checkbox"/> separation difficulties | <input type="checkbox"/> withdrawn |
| <input type="checkbox"/> easily frustrated/impulsive | <input type="checkbox"/> inappropriate behavior |
| <input type="checkbox"/> strong-willed | <input type="checkbox"/> self-abusive behavior |

Play Behaviors (check all that apply)...

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

- | | |
|---|---|
| <input type="checkbox"/> putting toys in mouth | <input type="checkbox"/> playing by self |
| <input type="checkbox"/> banging toys together | <input type="checkbox"/> taking turns |
| <input type="checkbox"/> throwing toys | <input type="checkbox"/> playing with toys in repetitive manner (spinning/lining up items, etc) |
| <input type="checkbox"/> shaking toys | <input type="checkbox"/> other: _____ |
| <input type="checkbox"/> pushing/pulling toys | _____ |
| <input type="checkbox"/> inattentive to toys | _____ |
| <input type="checkbox"/> appropriate use of objects | _____ |
| <input type="checkbox"/> uses one object for another | _____ |
| <input type="checkbox"/> acting out familiar routines | _____ |
| <input type="checkbox"/> role-playing | _____ |
| <input type="checkbox"/> make believe play | _____ |
| <input type="checkbox"/> games with rules | _____ |
| <input type="checkbox"/> rough and tumble play | _____ |
| <input type="checkbox"/> looking at books | _____ |
| <input type="checkbox"/> playing with others | _____ |

Please provide us with any additional information, which may be helpful for treatment:

Does CHI St. Joseph Health Rehabilitation Center have your permission to contact teachers, therapists, or other professionals by phone regarding your child's progress? Y / N

Form completed by:

Relationship to child:

Signature:

Date:
