Child Case History

Person filling out the form: ______________________________
Relationship to the child: ______________________________
Child's Name: ______________________ Today's Date __________
Date of Birth: ______________ Age: ____________ Gender:__________
Name of School ______________________ Grade: __________
Parent(s) / Guardian(s): ______________________________
Address: ______________________________
City, State, Zip: ______________________________
Phone #1:______________ ☐ Cell ☐ Home ☐ Work ☐ Other
Phone #2:______________ ☐ Cell ☐ Home ☐ Work ☐ Other
Email #1:______________ Email #2: ______________

How did you hear about All Clear Speech Therapy?
____

Family Background

Parent 1 Name: ______________________ Age: ________
Occupation/Education: ______________________________
Parent 2 Name: ______________________ Age: ________
Occupation/Education: ______________________________
Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

What adults does the child live with? Check all that apply:
☐Birth Parent(s) ☐Adoptive Parent(s) ☐Foster Parent(s)
☐Grandparent(s) ☐Both Parents ☐Parent 1 Only
☐Parent 2 Only ☐Other: ______________________________

Names and ages of other siblings and children in the home: ______________
____
____

Language(s) spoken in the home: ______________________________
Who speaks the other language(s)? ______________________________
Describe the child's use/understanding of the language(s): ______________
____

Is there anything additional you would like to share about the family / home environment?
____
____

Evaluation

Briefly describe why you're seeking an evaluation by a speech-language pathologist at this time: ____

____

What are you expecting out of this evaluation / meeting? ____

____

____

What age was the child when you first notice the problem? ___________________

Is the child aware of or frustrated by his/her communication difficulties? ___________

____

Has the child had a previous speech, language or feeding evaluation/treatment? ☐Yes ☐No
By whom: ___________________________When: _______________
Describe the results: ____

____

____

Has the child had any other therapies or seen any specialists? ☐Yes ☐No
By whom: ___________________________When: _______________
Describe the results: ____

____

____

If anyone else in the family has a speech, language or feeding diagnosis, please describe it:

____

____

____

Medical History

1. Were there any complications during pregnancy, labor, or delivery?
☐Yes ☐No Describe: ____

____

2. At how many weeks gestation was birth? ________ weeks (40 weeks is typical)
3. Was the child delayed in reaching any milestones (sitting, standing, walking, speaking, toileting, dressing, etc.)? ☐Yes ☐No
Describe: ____

____

Check and describe all that apply:

☐ Adenoidectomy
☐ Allergies:_______________
☐ Asthma
☐ Behavior Issues:________________
☐ Brain injury
☐ Breathing problems:_____________
☐ Cardiac issues:_________________
☐ Chicken pox
☐ Chronic illness:__________
☐ Diabetes
☐ Ear infections
☐ Ear tubes
☐ Encephalitis
☐ Frequent colds
☐ Hearing loss
☐ High fever
☐ Measles
☐ Meningitis
☐ Mumps
☐ Seizures
☐ Sensory issues:___________
☐ Sleep issues:_____________
☐ Tongue tie
☐ Tonsillitis
☐ Tonsillectomy
☐ Traumatic brain injury
☐ Vision issues :____________________
☐ Other :___________________________

Further descriptions of conditions you marked above: _______________________________
____
____

Is the child up to date with immunizations: ☐ Yes ☐ No
Notes: ____

Has the child ever had surgery or been hospitalized? ☐ Yes ☐ No
Please describe: ____
____
____

Has the child ever been in a serious accident? ☐ Yes ☐ No
Please describe: ____
____
____

Is the child currently on any medications? If so, please list medication name and reason for medication:____
____

Do you have any concerns with the child's hearing? ☐Yes ☐No
Describe: ____
____
____

Does the child do any of the following:

☐Choke on liquids
☐Choke on foods
☐Avoid foods
☐Maintain a special diet
☐Mouth objects
☐Use a pacifier / suck thumb

Please describe any of the above: ____

____

____

Does the child have any difficulty with the following:

☐Attention
☐Aggression
☐Answering simple questions
☐Understanding people
☐Excessive drooling
☐Producing speech sounds
☐Reading
☐Remembering
☐Transitions
☐Frustration Tolerance
☐Anger
☐Answering –wh questions
☐Following directions
☐Chewing or eating
☐Stuttering
☐School work
☐Maintaining eye contact
☐Word Retrieval
☐Other difficulties: ____

Please describe any of the above: ____

____

____

Social History

What are the child's favorite activities? ____

____

____

Does the child become easily frustrated with certain activities? If so, please explain:

____

____

____

What are the child's strengths and weaknesses? ____

____

____

Anything else we should know about the child? ____

____

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