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 (949) 842-9557

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._____