phone: 586-307-4757
fax: 855-393-6740
email: office@nhspeech.com
web: www.nhspeech.com

# Case History Form

## General Information

Child's Name:_____Date of Birth:_____
Address:_____ Phone:_____
City:_____ Zip:_____
Mother's Name:_____
Mother's Occupation:_____ Business Phone:_____
Father's Name:_____
Father's Occupation:_____ Business Phone:_____
Referred by:_____
Pediatrician:_____
Address:_____

Child's Siblings

| Name | Age | Speech Impairment? | Physical Impairment? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Is there a family history of speech, language or hearing problems in your family? If yes, please describe.

_____
_____

What is the primary language spoken in the home? Does the child have exposure to any language besides English?

_____
_____

What concerns you most about your child?

_____
_____

When was the problem first noticed?

_____
_____

How does the child usually communicate (gestures, pointing, single words, phrases, sentences)?_____

**Birth History**
Was this a full term pregnancy? _____ Was the child premature? If so by how many weeks?_____

Were there any medical problems following delivery? _____ If so please explain
_____
_____
_____
_____

Did your child go home with you? _____ If not how long did he/she remain in the hospital?_____

**Developmental History**
Provide the approximate age at which the child first did the following activities:

Sat unsupported_____
Crawled _____
Pulled to standing _____
Walked _____

Fed self (with hands)_____
Fed self (with utensils)_____
Used toilet _____
Dressed self _____

Did the child vocalize or babble as an infant?_____
At what age did he/she begin producing first words?_____
What were some of your child's first words?_____
When did your child begin producing two-word phrases (e.g. go home, hi mommy)_____
When did sentences emerge and were they clear?_____
Does the child point and/or grunt to make wants/needs known?_____

Has your child ever had any feeding or swallowing problems (e.g. problems with sucking, chewing, drooling, swallowing, gagging, vomiting, weight gain, etc.)? If yes please describe._____
_____
_____

Has your child has a hearing test?_____. If yes, when and where?_____
*Please provide a copy of the results*

Has your child ever been diagnosed with a medical disorder?_____ If so, by whom, when and what was the diagnosis?_____
_____
_____

Has your child had a speech/language evaluation prior to this one? ☐ Yes ☐ No
If yes, where? _____ When? _____
What were the recommendations? _____

Are there any special needs or circumstances that the clinician should be aware of?
_____

**Daily Behavior**

Does your child sleep well? ☐ Yes ☐ No
Does your child eat well? ☐ Yes ☐ No
Does your child more often ☐ Play alone ☐ Play with others
Age of playmates_____
How does your child get along with other children?_____
How does your child get along with adults?_____
Any behavioral problems?_____
What types of discipline are used?_____
What types are most effective?_____
What are some of your child's most preferred toys/games?
_____

**School Information**

Name of school: _____
Type of classroom: _____
Is your child receiving speech therapy in his/her school program? Yes☐ No ☐
If so, how often? _____

**General Health**

Describe any major illnesses or injuries your child has had: _____
_____
Describe child's overall health:_____
Medications taken: _____
_____
Allergies:_____
_____
Does your child have seizures? If yes, what are any known triggers: _____
_____
What are your goals/expectations for this evaluation?_____
_____

Is there anything else your would like us to know about your child that would impact our evaluation and/or treatment? _____
_____

Any additional comments: _____
_____

***I have received and read a copy of the payment and cancellation policies at this office. I understand that I am responsible for all charges not covered by insurance.***

Parent/guardian signature _____ Date: _____