Student Case History Form

Identification

Name of Child ______________________________ Date of birth ____________

Nickname ______________________________ Age ________ Grade ________

Address ______________________________ City ______________________________

With whom does this child live? ______________________________

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Family Information

Mother's' Name ______________________ Age ____ Occupation ______________

Phone contacts: Home/Cell ______________________ Work ______________

Notes: ______________________________

Father's Name ______________________ Age ____ Occupation ______________

Phone contacts: Home/Cell ______________________ Work ______________

Notes: ______________________________

Brothers and sisters (include names and ages) ______________________________

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Other family history/background information: ______________________________

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Statement of Concern

Describe as completely as possible your concerns about your child's speech and/or language.

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Speech and Language History

What languages are spoken in the home? What languages does this child speak? What is the primary language of the child? ____

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Is there any other speech, language, or hearing problems in your family? If yes, what is the problem? What is the relationship of this person to the child? ______________________________

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Is the child aware of the problem? If yes, how does he or she feel about it? ____________________

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How well is the child understood by parents, sibling, relatives, and strangers? __________________

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If the child has difficulty listening or understanding, please explain__________________________

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Have any other speech-language pathologists seen this child? If yes, what were the conclusions or suggestions? ____

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Have any other specialists (physician, psychologist, special education teachers, audiologists, etc) seen this child? If yes, indicate type of specialist, when child was seen, and specialist's conclusions or suggestions. ____

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Pregnancy and Birth History

If there were any unusual problems during pregnancy (illness, accident, medications, etc) please describe. ____

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If there were any unusual problems during or after labor and delivery, please describe.

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Developmental History

Provide an approximate age at which the child began to do the following activities:

Sat ____________ Crawl ____________ Walk ____________

Babbled ________ First Words ________ Use toilet ________

Put words together __________ Grasped Crayon/Pencil ________

Does the child have any difficulty walking, running, or participating in other activities which require small or large motor coordination (i.e.: writing, climbing, etc)? Yes No

If yes, please explain ____

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Are there or have there ever been any feeding problems (e.g.: problems with sucking, swallowing, drooling, chewing, etc) Yes No

If yes, please describe: ____

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Does your child currently put toys/objects in their mouth? ____________________________

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Does your child brush his/her teeth and/or allow brushing? ____________________________

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Medical History

Please check any of the following which the child has experienced or which the child has been diagnosed.

	Illness/condition	**Age(s) of occurrence**		**Illness/condition**	**Age(s) of occurrence**
	ADD/ADHD			Heart Problems	
	Adenoidectomy			High Fever(s)	
	Allergies			Measles	
	Asthma			Meningitis	
	Chicken Pox			Mumps	
	Cold			Pneumonia	
	Concussion			Seizure	
	Diabetes			Stroke	
	Ear Infections			Sinus Infections	
	Encephalitis			Tonsillitis	
	Headaches			Tonsillectomy	
	Head Injury			Tubes in Ears	

Other illness(s)/details ____

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If the child is currently under medical treatment or medication, please describe ____________

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Has your child had a hearing screening? When and did they pass? ___________________

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Has your child had a vision screening? When and did they pass? ____________________

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Education History

Is your child currently enrolled in a school? If yes, please list grade, school, city, and teacher. ________

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How is the child doing academically? Do teachers report any concerns? ______________________

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Does the child receive special services? ____

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How does the child interact with others (e.g.: shy, aggressive, uncooperative, outgoing, etc.)?

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What are the child's strengths and interests? ____

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Please provide any additional information that might be helpful in the evaluation or remediation of the child's struggles. ____

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Person completing this form (please print) ______________________________ Date ________________

Relationship to child ____________________________ Signature__________________________________

Thank you for completing this form. I appreciate your time and effort.