UNIVERSITY SPEECH-LANGUAGE-HEARING CLINIC

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CHILD/ADOLESCENT CASE HISTORY FORM

To assist us with learning more about your child's communication skills, please complete the following form. Write NA in the questions that do not apply to your child.

INTRODUCTION

Child's Name _____ Birthdate _____ Sex_____

What are your concerns about your child's communication?

_____

_____

_____

What do you want to know when we're done?

_____

_____

_____

What does your child do well?

_____

_____

_____

What does your child need help doing?

_____

_____

_____

Describe your child's favorite activities:

_____

_____

_____

BACKGROUND INFORMATION

Parents' Names: _____ _____

Address:_____ City: _____ State: _____Zip:_____

County: _____ Email: _____

Home Phone: _____ Cell Phone: _____

Mother's Work Phone: _____ Father's Work Phone: _____

School:_____ School District:_____Grade: _____

Teacher's Name: _____

School Address: _____ City _____ , State _____Zip:_____

Languages spoken in the home:_____ Primary Language:_____

Name of person completing this form:_____

Relationship to child:_____

Physician's name: _____ Physician's phone number: _____

Who referred you to this clinic? _____

Has the child been diagnosed with any of these? intellectual disability ____ cerebral palsy _____

down syndrome____ chronic middle ear infections_____ learning disability_____

attention deficit disorder ____ attention deficit hyperactivity disorder ____ down syndrome ____

central auditory processing disorder ____ cleft lip or palate____ emotional disability____

developmental delay____ autism spectrum disorder____

If you checked any of these, please tell when _____ and who made the diagnosis _____.

Does the child have any other diagnoses including medical diagnoses? _____

If so, please describe. _____ _____

BIRTH HISTORY

Describe the child's birth. Report any unusual conditions. _____

_____

COMMUNICATION DEVELOPMENT

Did the child make sounds during infancy?_____At approximately what age?_____

With or without you talking to him/her? _____ Age of first words_____

Age at which child put two words together (Ex. "Want cookie.") _____Age at which child put three words together (Ex. "Mommy go bye-bye.") _____ Did the child talk little or much? _____

Describe:_____

Any periods when the child quit talking?_____ Describe _____

Does the child have any trouble pronouncing words? _____ Does the child have difficulty understanding what is said? _____ Does the child have difficulty expressing her/himself verbally?_____

If yes, describe. _____

Has there been previous speech/language testing? _____ If yes, by whom? _____

When?_____ Where?_____

Results: _____

Have there been any relatives with speech/language problems? _____ If yes, please state relationship(s) and the problem(s)_____

_____

MOTOR DEVELOPMENT

Age of holding head up: _____ Age of sitting up:_____

Age of first steps alone: _____ Describe Coordination: _____

MEDICAL HISTORY

VISION

Date of last vision examination? _____

Results? _____

Describe any history with vision problems. _____

Describe any history with glasses (age they were prescribed. When are glasses worn?)

_____

HEARING

Date of last hearing examination? _____

Results? _____

Describe any history with ear infections (ages, medications, PE tubes, etc.)

_____

Describe any history with hearing aids/ cochlear implants (ages, which ear/s, types of aid, etc.)

_____

SEIZURES

If the child has had any seizures, please explain: (Dates, all medications, results, current status)

_____

_____

If the child has a history of fainting spells, please explain: (Dates, situation, medical tests, results, current status)

_____

ALLERGIES

Please list all known allergies: _____

_____

Please describe immediate action to be taken in case of contact with allergen (s): _____

_____

GENERAL MEDICAL

Age of bladder control during the day _____During the night _____

Describe any sleeping problems.

_____

SCHOOL HISTORY

Child's grade level: _____

Describe your child's strengths at school:

_____

_____

Check any areas that are problems at school, then elaborate in the space below:

Subjects: Reading ____ Writing ____ Spelling ____ Math ____ Content areas (e.g., history) _____

_____

Skills: Paying attention ____ expressing him/herself ____ memory ____ getting along with peers ____

working independently ____ other things you notice (please describe) ____

_____

_____

_____

Does your child receive any of the following supports?

Special education (specify the reason)

_____

Resource room (describe)

_____

Tutoring (describe)

_____

Observations:

What do teachers say? _____

What do you notice?

_____

Describe any changes over time:

_____

How are your child's grades?

_____

SOCIAL AND HOME ENVIRONMENT

Home environment:

Who lives with the child now?
Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Who else does the child regularly spend time with?
Name: _____ Relationship**:** _____

Child's race/ethnic group: Caucasian_____ non-Hispanic _____ Hispanic _____

African American ____ Native American _____ Asian or Pacific Islander _____ Other _____

Describe any learning/developmental/social/medical problems in the family: _____

Social:

Does your child have friends? Many?_____A few _____ Very few_____

Does your child mostly socialize with children: his own age? _____Younger? _____ Older? _____

What is the child's attitude toward the speech problem?_____

What is the attitude of the family & friends towards the child's speech problems? _____

_____

ADDITIONAL QUESTIONS OR COMMENTS:

_____

_____

_____