



COLORADO SPEECH THERAPY SERVICES

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Child Case History Form

Today's Date: _____

I. Identifying Information

Child's Name: _____ Age: _____ Birthdate: _____ Sex of Child: M F

Child's Home Address: _____

City: _____ State: _____ Zip: _____

Names of Parents/Guardian:

Mother: _____

Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____

Phone: Home: _____ Work: _____

Father: _____

Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____

Phone: Home _____ Work _____

Are languages other than English (including sign language) used at home? Yes No

If so, what language? _____

Referral Source

Child Referred By: _____

Primary Pediatrician: _____

MD Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____

If Primary MD was not the referral source, do you want reports forwarded to them? Yes No

Reason for referral: _____

II. Parent/Guardian Input

Describe your concerns about your child's speech-language and hearing: _____

1. When was this problem first noticed? _____

2. What do you expect from this evaluation? _____

3. Why are you seeking services at this time? _____

4. Do you feel that your child hears well? Yes No

5. Date of most recent hearing evaluation: _____ Results: _____

6. Where was testing performed? _____

7. Who performed the testing? _____

8. Has the child ever been exposed to a loud noise or explosion? _____

9. Has the child ever had an ear infection? If so, which ear? _____

10. How long did the ear infection last? _____

Last occurrence First occurrence How often do they occur? _____

11. Does the child presently have or in the past had draining ears (pus, blood, etc.)? Yes No

12. Does the child ever complain of ear noises (tinnitus) such as ringing, buzzing, pulsing, etc.? Yes No

13. Is the child able to locate the direction from which sound is coming? Yes No

14. Does your child hear the same from day to day? Yes No

15. Does your child favor one ear? If so, which ear? Right Left

16. Does your child respond to vibration caused by loud sounds (door slam, truck driving by, airplane, radio in car, boom box vibration, etc.)? Yes No

17. Does the child watch the speaker's face when listening?

18. Does your child wear hearing aids? Right ear Left ear Both ears

Make and Model: _____

19. How long has he/she worn hearing aids? _____

20. How many hours a day does your child wear the hearing aids? _____

III. Speech and Language

1. Did the child begin to babble or talk and then stop? Yes No

If yes, please explain _____

2. What means of communication are currently being used: (circle all that apply)

- | | | | |
|-----------------------------------|--------------------|-------------------------|------------------|
| Vocalizations | 1-Word utterances | Simple 2-4 Word Phrases | Simple Sentences |
| | Complex Utterances | Facial Expressions | Gestures |
| Augmentative Communication Device | Body Gestures | "Show and Tell" | Pointing |

2a. List any adaptive equipment currently used: _____

3. At what age did your child say his/her first word? _____

4. What were the child's first few words? _____

5. Approximately how many words did the child have at 18 months? _____ 24 months? _____

6. At what age did the child say his/her first sentence? _____

Please give some examples of first sentences: _____

Please give an example of typical sentences the child currently uses: _____

7. How often does your child use speech? Frequently Sometimes Rarely

8. How does your child make his/her needs known? _____

9. Does the child use gestures often? Yes No

If so, give an example _____

9. What does the child use the most? Gestures Sounds One or two words

A. Phrases and Complete Sentences

1. Estimate the percentage of time that the child is understood by:

Unfamiliar listeners ___ Parents ___ Other adults ___ Brothers and Sisters ___ Friends ___

2. How well does the child understand what is said to him/her? _____

3. Please indicate the child's current level of understanding. Circle all that apply:

- Understands gestures Does not understand spoken words Understands single words
Understands simple sentences Understands 2 and 3 part commands Understands conversation

4. Do you think the child is aware of his /her communication difference? Yes No

4a. If yes, please describe how the child shows awareness. _____

5. Provide any other information about your child's communication that is of concern to you. _____

6. What have immediate family and/or relatives done to help the child overcome his/her communication difficulties ? _____

a. Has this helped? Yes No Explain: _____

7. What do you think caused this communication difference? _____

8. Please provide any additional information you feel will help us in understanding the child and his/her present communication ability. _____

IV. Prenatal (pregnancy), Birth, and Development

1. Mother's age when child was born: _____

Length of pregnancy in weeks: _____

Father's age when child was born: _____

2. Did the mother experience bleeding during pregnancy? Yes No

3. Did the mother have measles during pregnancy? Yes No

4. Did the mother have high blood pressure during pregnancy? Yes No

5. Did the mother experience leakage of membranes during pregnancy? Yes No

6. Were there complications during this pregnancy? (anemia, dehydration, diabetes, kidney infection, severe nausea, toxemia, accidents, other) Yes No

If so, please describe condition and medical attention received: _____

7. Were prescription/non-prescription drugs (including alcohol) taken during pregnancy? Yes No

If so, please list: _____

8. Did the mother have a normal delivery with this child? Yes No Breech delivery? Yes No

Caesarean Section delivery? Yes No

9. Were there birth injuries? Please describe: _____

10. Breathing difficulties (e.g., blue baby, required oxygen, stopped breathing, apnea, other) Yes No

11. Special instruments used during delivery? Yes No

If so, please describe _____

11. Was the baby jaundiced at birth? Yes No Rh incompatible? Yes No

12. What was the baby's birth weight? _____

One minute Apgar? _____ Five minute Apgar? _____

13. Were there any problems or complication immediately following birth or during the 1st two weeks of your infant's life (feeding, seizures, sleeping, swallowing, hospitalizations, etc.)? Yes No

14. How long was the infant's stay in the hospital following birth? _____

15..Development (give age when flrst occurred):

Held head up _____ Sat up unsupported _____ Stood alone _____ Fed self with spoon _____

Bowel trained _____ Undressed Self _____ Reached for object _____ Crawled _____

Walked alone _____ Bladder Trained _____ Dressed Self _____

16. What motor &/or self-help development concerns do you have for this child? _____

17. Would you describe your child's coordination as: good fair poor

Please explain: _____

V. Child's Medical History

1. Please check all conditions that your child has had or presently has:

allergies chicken pox croup encephalitis headaches heart problems measles
muscle disorder pneumonia rheumatic fever whooping cough Feeding or swallowing
problems asthma convulsions dental problems epilepsy/seizures head injury
high fevers meningitis nerve disorder polio cerebral palsy stroke failure to thrive

HIV Fetal Alcohol Syndrome blood disease crossed eyes diphtheria apraxia
 dysarthria influenza mumps traumatic brain injury bronchopulmonary dysplasia
 tracheostomy Gastro-esophageal reflux Neonatal Drug Dependence

A. Vision

1. Does your child have any visual problems? Yes No

If so, please describe: _____

2. Date of most recent vision testing _____

3. Where was the testing done? _____

4. Does your child wear glasses? Yes No

B. Ear, Nose, and Throat

1. Please check all conditions that your child has had or presently has:

chronic cough/colds hoarse voice difficulty swallowing tonsillitis
 tonsillectomy adenoidectomy tongue deformity jaw deformity cleft palate/lip
 speech problem ear deformity dizziness too much wax in ears
 pressure equalization tubes

2. Please list any medications the child is taking presently: _____

3. If your child has been seen by a medical specialist, hospital, clinic, agency, etc., please list below:

Agency/Specialist _____ Date: _____

What was done? _____

Results/Recommendation: _____

VI. Educational History

1. Does your child attend day care kindergarten school other _____

2. Name of School Current Grade Type of Class

Address: _____ Phone: _____

City: _____ County: _____ State: _____ Zip: _____

3. Teacher's Name: _____

4. Name of Speech Language Pathologist: _____

5. Does your child have a current IEP? Yes No

If yes, please have the school provide CO Speech Therapy Services at copy.

VII. Home and Family

1. Please list other family member(s) who have a hearing loss (before age 50) or speech/language or learning difficulties (brothers, sisters, mother, father, and extended family such as grandparents, cousins, etc.): _____

2. List significant activities, interests, events, hobbies, favorite toys, etc. for this child.

The assessment cannot proceed without the signature of the legal guardian.

Signature of Parent/Guardian: _____ Date: _____

Thank you.