Pediatric Speech and Language Case History Form

Child's Name: ____ Date of Birth: ________________
Parent/Guardian(s) ____

Please take the time to fill out the case history form to the best of your ability. The information obtained from this form will help us with the speech and language evaluation.

Developmental History:

Please indicate the approximate age your child reached the following milestones:

_____Sat Up Alone _____grasped/held crayon or pencil

_____Babbled _____Said first words

_____Put two words together _____Spoke in short sentences

____Walked independently _____Toilet trained

Background Information of Speech and Language Problems:

Primary Language Spoken in Home: _______________________

Describe the speech and language problems you notice with your child: (ex: not talking, using only few words, using one word, saying words incorrectly, repeating words)
____
____
____

Is your child aware of his/her speech/language problem? Y or N. Is the child frustrated by his/her speech and language difficulties? Y or N

If yes, Explain:
____
____

Is your child's speech and/or language difficulties noticed by others? Y or N
If yes, please tell who.
____

Has your child ever had a speech/language evaluation? Y or N. If yes, Where and When?
Attach a copy of evaluation.
____
____

Has your child received speech therapy in a school or any other setting? Y or N

Name of School/clinic/program: ___________________________________

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Dates of Service: ________________________________

Results: ____

If yes, please attach a copy of Individualized Education Plan or treatment plan.

Has your child had a hearing screening? Y or N

Do you have any concerns about your child's hearing? Y or N. If yes, Describe:

____
____

Does your child have any feeding problems (problems with sucking, swallowing, drooling, chewing, etc). Y or N. If yes, please describe.

____

Does your child have any other disability? Y or N. If yes, please check the appropriate box.

□ Autism Spectrum Disorder □ Asperger's Syndrome □ Intellectual Disability

□ Specific Learning Disorder □ Cerebral Palsy □ Down Syndrome

□ Attention Deficit Disorder □Attention Deficit Hyperactive Disorder

□ Emotional Behavior Disorder □ Reading Disorder □ Other__________

Does your child have any allergies? ____

Please list any medications your child takes regularly:

____
____

Current Speech and Language Function:

Receptive Language (how your child understands things said to them)

Does your child (please check what applies only)?

___identify common objects (chair, table) ___ understand/follow commands (get cup, come here)

___identify actions (run, walk, talk) ____ respond correctly to "wh" questions (who, what)

___respond correctly to yes/no questions ____ understand basic concepts (up/down, in/out)

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Expressive Language (how your child uses words to express what they understand)

___ pointing ___babbling (ba-ba, da-da)

___one word sentence ___two word combinations ("want cup")

___three or more words ___ask questions

___uses position words (in/out, up/down ___uses descriptive words (big/little, good)

___uses action words (walk, run, talk) ___uses pronouns (me, mine, yours)

Articulation (how your child produces words)

___ Substitute sounds (says "to" for "shoe") ___says sounds wrong while reading

___leaves off ending sounds ("cu" for "cup") _____spells the way he/she speaks

___leaves off beginning sounds ("up" for "cup")

____says specific sounds incorrectly. List sounds_______________

Fluency (how smooth the flow of speech is)

___repeats words, phrases

___long pauses between words

___ prolongs words or sounds

___abnormal mouth or head movements when speaking

Voice and Resonance (how voice sounds)

___hoarse ___strained ___raspy

__too low ___to high ___ whispery

Social Skills (how your child interacts with others)

___uses social greetings (hi, bye) ___makes eye contact

___plays well with others ___shares toys/things easily

___initiate play with others ___takes turns

SPEECH THERAPY EVALUATION QUESTIONAIRE

What is the reason for the Speech Therapy Referral?

Does your child go to school, preschool, or daycare? If so,

Where?

How often?

Do they receive speech services at school?

Are there any difficulties that we should be aware of before the evaluations (i.e. vision, hearing, behavior, motor etc.)?

Has your child had any other evaluations at another facility or at school (i.e. ST, OT, PT, psychological, swallowing, AAC, hearing)? If so **PLEASE BRING A COPY OF THESE EVALUATIONS TO YOUR EVALUATION APPOINTMENT.**

Have you noticed any drooling, difficulty chewing, coughing, or gagging when swallowing food or drinking? If so, please explain.

Can your child follow directions? (i.e. "Go to the kitchen and get a fork.")

How does your child tell you what they want? (I.e. grunts, points, use words etc.?

Do other people have difficulty understanding your child?

What are some things that your child likes to do or toys he/she likes to play with at home?

Is your child on any medications? Please list and name. What is the medication for? Are there any side effects? Please list.

Has your child had or has an AAC device? If so what is the name of it?