# Having Our Say Speech & Language Services, LLC

## CASE HISTORY FORM – CHILDREN

Child's Name: _____ Date of Birth: _____

Address: _____ Age: _____ Gender: _____

City_____State____Zip_____ Home Phone: _____

Child Lives With: Both Parents _____ Mother _____ Father ____ Guardian:_____

If Divorced, who has custody? Joint ___ Mother ___ Father ___ Other:_____

Father's Name: _____ Mother's Name: _____

Occupation: _____ Occupation: _____

Home:_____ Home:_____

Cell: _____ Cell: _____

Work: _____ Work: _____

E-mail _____ E-mail _____

Siblings: Age: Other people in the home:

_____ _____ _____ Relation_____

_____ _____ _____ Relation_____

_____ _____ _____ Relation_____

How did you hear about **Having Our Say LLC**

□ Family member _____ □ Internet

□ Friend _____ □ Phone book

□ Teacher _____ □ Workshop

□ Doctor _____ □ Insurance network

Child's Physician: _____ Phone number: _____

Address: _____ City: _____

Client Name:_____

Developmental History

Please complete this section to the best of your ability.

| Please check appropriate box: | Yes | No | Unknown | Comments |
|---|---|---|---|---|
| Is the child adopted? | | | | If yes, at age did the child join the family? |
| Normal pregnancy and delivery? | | | | |
| Weight at birth? | | | | |
| Vaginal delivery? | | | | |
| - were forceps used? | | | | |
| - was the vacuum used? | | | | |
| Cesarean delivery? | | | | Emergency or planned? |
| Full-term pregnancy? | | | | How many weeks early? |
| Alcohol, drugs, smoking or any medications during this pregnancy? If so, please list. | | | | |
| Did your child have jaundice? | | | | Need Photo-therapy? |
| Was oxygen or respiratory assistance required after birth? | | | | |
| Was your child breastfed? | | | | |
| Any difficulties with feeding? | | | | |
| Did your child have normal feeding, weight gain, sleeping cycles, and temperament? | | | | |

| Milestones (check box) | Within Normal Limits | Not Within Normal Limits | Comments |
|---|---|---|---|
| Rolling Over | | | |
| Babbling | | | |
| Sitting Independently | | | |
| Crawling | | | |
| Walking | | | |
| First Words | | | |
| 2 word phrases | | | |
| Jumping | | | |
| Throwing/Catching a ball | | | |
| Climbing Stairs | | | |

Client Name:_____

**Medical History**

History of ear infections? _____ How many? _____ When did they start? _____

Tubes in ears? _____ When were they placed? _____

Removal of tonsils or adenoids? _____ When was it performed? _____

Does/ did your child use a pacifier?_____ Until when? _____

Suck his/her thumb? _____ Until when?_____

Please list any allergies (including seasonal and food): _____

_____

Any medication for allergies? _____

Vision difficulties? _____ Wears glasses/ contacts? _____

Near or Far-Sighted? _____ Reading Only? _____

Please list any other current medications taken, how often they are taken, and for what treatment:

_____

_____

Please list any medical conditions: _____

_____

Please list any hospitalizations and/or surgeries and the date(s) _____

_____

**Speech-Language History**

Please check the areas of speech/language for which you have concern:

□ Articulation □ Oral Motor □ Receptive Language □ Expressive Language

□ Vocabulary □ Fluency (Stuttering) □ Auditory Processing □ Reading

□ Voice □ Pragmatics (social skills)

Client Name:_____

*Please check if you notice any of the following with your child:*

**Articulation:**

____ mispronounces those sounds that are typically pronounced correctly by peers
____ says single words clearly but is difficult to understand in conversation
____ deletes parts of words (ie. says "ca" for "cat")

**Oral Motor:**

____messy eater
____avoids certain foods
____drools (at rest or while eating)
____sensitive gag reflex
____swallowing difficulties
____coughing while eating or drinking

**Fluency:**

____ stutters on individual sounds or syllables (i.e. "t-t-table" or "ta-ta-table")
____ repeats whole words or phrases
____ stutters in most environments (i.e. playground, classroom, home, etc.)
____ has "blocks" so that no sound is coming out but effort is being made to talk
____ uses excessive filler words (i.e. "um," "like," and "you know")

**Expressive Language:**

____ has trouble expressing wants and needs
____ repeats or echoes what others have said without apparent understanding
____ has difficulty forming and/or answering questions
____ has difficulty generating sentences

**Receptive Language:**

____ has difficulty following the daily routine
____ has difficulty understanding/ remembering/ following verbal directions
____ looks around the room to see what others are doing when given oral directions
____ lacks an understanding of basic concepts ( i.e. "on," "first," "empty," etc.)

**Vocabulary:**

____ has a weak expressive vocabulary (uses vague words, such as "that thing")
How many words are in your child's vocabulary?
Receptive vocabulary (words that are understood) □ Under 25 □ 25-75 □ over 75
Expressive vocabulary (words that are spoken) □ Under 25 □ 25-75 □ over 75

**Pragmatics:**

____ has difficulty initiating and/or maintaining a conversation
____ has difficulty with eye contact
____ lacks ability to interpret body language (i.e. gestures, facial expressions, etc.)
____ demonstrates difficulty with turn-taking

Client Name:_____

Is there a family history of speech/language disorders? _____

Please describe._____

_____

Is your child bilingual?_____

If yes, what languages does your child understand? _____

What settings is your child spoken to in English?

_____

What percentage of the time does your child hear English at home? _____%

at school? _____%

Do you find that the concerns you have about your child's speech/language is the same in both languages?

□ Yes □ No □ Not sure

Please describe any other speech/language concerns_____

_____

**Social History**

Please indicate which characteristics describe your child:

| | | | |
|---|---|---|---|
| □ Over reacts | □ Content | □ Compliant | □ Unusual Fears |
| □ Stubborn | □ Frustrated | □ Impulsive | □ Plays well with others |
| □ Avoids touch | □ Restless | □ Quiet | □ Sensitive |
| □ Difficulty separating | □ Happy | □ Clumsy | □ Difficulty with Learning |
| □ Fatigues Easily | □ Shy | □ Resistive | □ Friendly |
| □ Poor attention | □ Helpful | □ Nervous habits | □ Eager to please |
| □ Trouble sleeping | □ Shares well | □ Affectionate | □ Outgoing |
| □ Prefers to play alone | □ Avoids eye contact | | |

Client Name:_____

Please describe your child's favorite activities:_____

_____

Please list the opportunities your child has for social interaction with peers: _____

_____

**Educational History**

Name of current school _____ Current grade _____

Teacher's name _____ Does your child enjoy school? _____

Does your child demonstrate difficulty in any specific subjects? _____

_____

Does your child have a current Individualized Education Plan (IEP)? _____

If yes, please provide a copy of the current IEP to include in your child's file.

Which Least Restrictive Environment is meeting your child's needs?

Push-In Services_____ Pull-Out_____ 1:1 Aide_____ Self-Contained Classroom ____

Which of the following support services does your child receive at school and for how many minutes per week:

_____ Resource How many minutes? _____

_____ Speech/Language _____

_____ Social Work _____

_____ Hearing Itinerant _____

_____ Psychologist _____

_____ Occupational Therapy _____

_____Other: _____ _____

What goals are being targeted during these services? _____

_____

_____

Client Name:_____

**Related Services**

Has your child ever been evaluated by a Speech Pathologist? _____

If so, what were the results?_____

_____

Was treatment recommended? _____ How long did your child receive treatment?_____

Name of the Speech Pathologist:_____ Phone: _____

Has your child ever been evaluated by a Psychologist? _____

If so, what were the results?_____

_____

Was treatment recommended? _____ How long did your child receive treatment?_____

Name of the Psychologist:_____ Phone: _____

Has your child ever been evaluated by an Occupational Therapist? _____

If so, what were the results?_____

_____

Was treatment recommended? _____ How long did your child receive treatment?_____

Name of the Occupational Therapist:_____ Phone: _____

Has your child ever been evaluated by an ENT? _____

If so, what were the results?_____

_____

Name of the ENT:_____ Phone: _____

Has your child ever been evaluated by an Audiologist? _____

If so, what were the results?_____

_____

Was treatment recommended? _____ How long did your child receive treatment?_____

Name of the Audiologist:_____ Phone: _____

Has your child ever been evaluated by a developmental ophthalmologist? _____

If so, what were the results?_____

_____

Was treatment recommended? _____ How long did your child receive treatment?_____

Name of the professional:_____ Phone: _____