SPEECH-LANGUAGE-HEARING CASE HISTORY FORM

Identifying and Family Information:

Child's Name: ______________________ Birthdate: ______________ Sex: ☐ M ☐ F

Father's Name: ______________________ Daytime Phone: ______________________

Address: ______________________ Cell Phone: ______________________

______________________ E-mail: ______________________

____

Mother's Name: ______________________ Daytime Phone: ______________________

Address: ______________________ Cell Phone: ______________________

______________________ E-mail: ______________________

____

Other children in the family:

Name	Age	Sex	Grade	Speech/Hearing Problems

Child's race/ethnic group:

☐ Caucasian, Non-Hispanic ☐ Hispanic ☐ African-American

☐ Native American ☐ Asian or Pacific Islander ☐ Other __________

Is there a language other than English spoken in the home? ☐ Yes ☐ No

If yes, which one? ______________________________________

Does the child speak the language? ☐ Yes ☐ No

Does the child understand the language? ☐ Yes ☐ No

Who speaks the language? ______________________________________

Which language does the child prefer to speak at home? ______________________

SPEECH-LANGUAGE-HEARING

Do you feel your child has a speech problem? ☐ Yes ☐ No

If yes, please describe: ______________________________

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Do you feel your child has a hearing problem? ☐ Yes ☐ No

If yes, please describe: ______________________________

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Has he/she ever had a speech evaluation/screening? ☐ Yes ☐ No

If yes, where and when? ______________________________

What were you told? ______________________________

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____

Has he/she ever had a hearing evaluation/screening? ☐ Yes ☐ No

If yes, where and when? ______________________________

What were you told? ______________________________

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Has your child ever had speech therapy? ☐ Yes ☐ No

If yes, where and when? ______________________________

What was he/she working on? ______________________________

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Has your child received any other evaluation or therapy (physical therapy, counseling, occupational therapy, vision, etc)? ☐ Yes ☐ No

If yes, please describe: ______________________________

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Is your child aware of, or frustrated by, any speech/language difficulties? ______________________________

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What do you see as your child's most difficult problem in the home? ______________________________

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What do you see as your child's most difficult problem in school? ______________________________

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Birth History

Was there anything unusual about the pregnancy or birth? ☐ Yes ☐ No

If yes, please describe: ____

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How old was the mother when the child was born? ____________

Was the mother sick during the pregnancy? ☐ Yes ☐ No

If yes, please describe: ____

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How many months was the pregnancy? ____________

Did the child go home with his/her mother from the hospital? ☐ Yes ☐ No

If child stayed at the hospital, please describe why and how long: ____________________

____

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Medical History

Has your child had the following:

☐ adenoidectomy
☐ allergies
☐ breathing difficulties
☐ chicken pox
☐ colds
☐ ear infections
how often? ____________
☐ ear tubes

☐ encephalitis
☐ flu
☐ head injury
☐ high fevers
☐ measles
☐ meningitis
☐ mumps
☐ scarlet fever

☐ seizures
☐ sinusitis
☐ sleeping difficulties
☐ thumb/finger sucking habit
☐ tonsillectomy
☐ tonsillitis
☐ vision problems

Other serious injury/surgery: ____

Is your child currently (or recently) under a physician's care? ☐ Yes ☐ No

If yes, why: ____

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Please list any medications your child takes regularly? ______________________________

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