Speech Therapy Child Case History Form

Identifying & Family Information:

Child's Name: _____ Date of Birth: _____ CA: _____ (For Office Use)

Mother's Name: _____ Daytime Phone: _____
Address: _____ Cell Phone: _____
_____ Email: _____

Father's Name: _____ Daytime Phone: _____
Address: _____ Cell Phone: _____
_____ Email: _____

Doctor's Name: _____ Doctor's Phone: _____
Referred by: _____ Phone: _____

Child Lives with (Check One:)

□ Birth Parents □ Foster Parents □ One Parent (Choose one: Mother)
□ Adoptive Parents □ Parent & Stepparent □ Grandparent □ Other_____

Other Children in the Family: (Use the back of this page if additional space is needed)

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. Which language? _____
Who speaks the language? _____
Which language does the child prefer to speak at home? _____

Speech- Language-Hearing

Please describe your child's speech problem. □ Yes □ No

_____

_____

How many words does your child have? _____ Any 2–5 word phrases/ sentences? □ Yes □ No
List words or phrases child uses: _____

_____

How does the child usually communicate (hand gestures, single words, short phrases, sentences)?_____

_____

Has he/ she ever had a hearing evaluation/ screening? □ Yes □ No
If yes, where & when? _____
What were the results? _____

_____

Has he/ she ever had a speech evaluation/ screening? □ Yes □ No
If yes, where & when? _____
What were the results? _____

_____

Has your child ever participated in speech therapy? □ Yes □ No
If yes, where, when & how long? _____
What was he/ she working on? _____

_____

****Please list current or most recent Speech Therapist name & phone number****

_____

Has your child participated in any other evaluation or therapy (physical therapy, occupational therapy, early intervention, behavioral therapy, counseling, etc.?) □ Yes □ No
If yes, please give details. _____

_____

_____

Does your child appear to be aware of, or frustrated by his/ her speech/language difficulties?

_____

What do you believe is your child's most difficult problem with communication in the home?

_____

At School? _____

Birth History

Was there anything unusual that may have affected the pregnancy or birth? □ Yes □ No
If yes, please describe_____

_____

_____

Was the mother sick or have any complications during the pregnancy? □ Yes □ No
If yes, please describe _____

_____

How many months was the pregnancy? _____ Birth Weight: ___ lbs. ___oz.
Did the baby go home with his/ her mother from the hospital? □ Yes □ No
If the baby stayed at the hospital, please describe how long & why _____

_____

_____

_____

_____

Medical History:

Has your child experienced any of the following?

□ adenoidectomy	□ encephalitis	□ seizures	□ tonsillectomy
□ allergies	□ asthma	□ sinusitis	□ tonsillitis
□ breathing difficulties	□head injury	□ high fevers	□ chicken pox
□ sleeping difficulties	□ mumps	□ measles	□ meningitis
□ thumb/ finger sucking	□ scarlet fever	□ vision problems	□ frequent colds
□ ear infections	□ ear tubes	□ pneumonia	□ flu
how often?_____	□ mastoiditis	□ German measles	□ tinnitus

□ Other:_____

Hospitalization(s), serious injury, or surgeries (What & when)? _____

_____

_____

Is your child currently (or have recently been) under a physician's care? □ Yes □ No
If yes, why? _____

Please list any medications your child takes regularly & reason for the medication(s):

_____

_____

Developmental History:

Please provide the approximate age your child achieved the following developmental milestones:

_____ sit alone _____ crawl _____ stand _____ Walked
_____ babbled _____ said 1st words _____ put 2 words together
_____ feed self _____ dress self _____ toilet trained
_____ spoke in short sentences _____ grasped crayon/ pencil

Use Single words (e.g.) no, mom, doggie) _____
Combine words (e.g., me go, daddy shoe) _____
Name simple objects: (e.g., dog, car, tree) _____
Use simple questions: (e.g., where's doggie?) _____
Engage in a conversation _____

Does your child:

Choke on food or liquids? □ Yes □ No *Which Foods or liquids?_____
Currently put toys or objects in his/ her mouth? □ Yes □ No
Brush his/ her teeth and/ or allow brushing? □ Yes □ No

Are there or have there ever been any feeding problems (e.g., problems with suckling, swallowing, drooling, chewing)? □ Yes □ No
If yes, describe _____

_____

Does your child have difficulty walking, running, or participating in other activities that require small or large muscle coordination? □ Yes □ No
If yes, describe _____

Describe the child's response to sounds (e.g., responds to all sounds, responds to loud sounds only, inconsistently responds to sounds). □ Yes □ No
Please describe: _____

Current Speech- Language Hearing:

Does your child.....

□ repeat sounds, words, or phrases over and over?
□ understand what you are saying?
□ retrieve/ point to common objects upon request (ball, cup, shoe)?
□ follow simple directions ("Shut the door" or "Get your shoes")?
□ respond correctly to yes/ no questions?
□ respond correctly to who/what/where/when/why questions?

Your child currently communicates using.....

□ body language.
□ sounds (vowels, grunting).
□ words (shoe, doggy, up.)
□ 2-4 word phrases/ sentences.
□ sentences longer than four words.
□ other_____.

Behavioral Characteristics:

□ cooperative
□ attentive
□ willing to try new activities
□ plays alone for reasonable length of time
□ separation difficulties
□ easily frustrated/ impulsive
□ stubborn
□ shy
□ uncooperative
□ poor eye contact
□ easily distracted/ short attention span
□ destructive/ aggressive
□ withdrawn
□ inappropriate behavior
□ self- abusive behavior
□ restless

Educational/ School History/ Daycare History:

School/ Daycare Name: _____ Grade: _____
Will child be seen for therapy at Daycare? □ Yes □ No
Daycare Address/ Location: _____
Daycare Phone Number_____ Lunch Time_____ Nap Time _____

Teacher Name(s): _____

Has your child repeated a grade? □ Yes □ No If so, which grade(s) _____

What are your child's strengths and/ or best subjects? _____
_____

Is your child having difficulty with any subjects? □ Yes □ No
If so, which subject(s) _____

Does your child receive any special services at school? If yes, please describe:
_____
_____

If receiving special services, has an Individualized Educational Plan (IEP) been developed?
□ Yes □ No If yes, please describe his/ her goals:
_____
_____

Please provide any additional information that might be helpful for the child's evaluation:
_____

Vaccination Status:

Has anyone in your household been fully vaccinated for COVID-19? (Fully vaccinated, meaning, have received both shot doses, with the 2nd shot taken at least 10 days ago.)

□ Yes □ No

Please list recipients' names (within your household,) who have received the COVID- 19 vaccine. _____

_____

If the answer to the above question is no, do you and your household plan to be vaccinated?
□ Yes □ No If so, when? _____

Photography Release: *(Initial ONE response)*

_____ **Yes**, I consent for photographs and/or video images to be taken of me by SpeakEasy Therapy Factory, LLC. or a representative. I understand the images will be a part of my medical record and may be used for purposes of medical teaching or training or for marketing purposes (website, print, digital or social media). By consenting to photographs and/or video images I understand I will not be compensated from any party. Although photographs and/or video images will be used without identifying information such as name, I understand it is possible someone may recognize me. I further acknowledge that my participation is voluntary and agree that use of any photographs and/or video images confers no rights of ownership or royalties whatsoever.

_____ **No**, I decline to give consent for use of photo(s) and video(s) of my child during therapy. I understand that declining will not impact the quality of therapy services that my child receives.

Person completing form: _____ Relationship to client: _____

Signature: _____ Date: _____ Phone#: _____

Please return this competed form to SpeakEasy Therapy Factory prior to initial visit via fax or email. Thank you!

info@speakeasytherapyfactory.com **Fax: 803-470-4709** **Phone: 803-400-6334**