Therapy Connections, P.C.

Child Case History

Child's Name: _____ DOB: _____

Address: _____ Phone: _____

Parent's Names: _____

General Information

1) Name of brothers and sisters (include ages):

2) What is the child's primary language?

3) Does the child speak any other languages?

4) With whom does the child spend most of his/her time?

5) Describe the child's speech and/or language problem.

6) How does the child usually communicate? (gestures, signs, single words, phrases, sentences)

7) When was the problem first noticed and by whom?

8) What do you think may have caused the problem?

9) Has the problem changed since first noticed? (describe)

10) Do others in the family have the same or similar problems? (describe)

11) Does the child notice this problem and if so, how does he/she feel about it?

12) Has any other speech-language pathologist seen the child? If so, who, when and what were their conclusions regarding your child's speech and language skills?

13) Have any other specialists seen your child? (Psychologist, physicians, special education teachers, etc.) If yes, indicate the type of specialist and, when the child was seen and, any conclusions or suggestions from the specialist.

14) Does your child have a history of ear infections or related hearing problems?

Prenatal and Birth History

15) Describe mother's general health during pregnancy. (Illnesses, accidents, medications, etc.)

16) Length of pregnancy?

17) General condition of child at birth?

18) Type of delivery?

19) Were there any unusual conditions that may have affected the pregnancy or birth?

Medical History

20) Have there been any other health conditions, illnesses, or surgeries/ hospitalizations regarding your child? If so, please describe.

21) Is your child taking any medications? If yes, please list.

Developmental History

22) When did your child begin to perform the following activities?

Crawl_____ Sit_____ Stand_____ Walk_____ Feed self_____

Dress self_____ Use toilet_____ Use single words_____

Combine words_____ Name simple objects_____

Use simple questions_____ Engage in conversation _____

23) Have there ever been any feeding problems?

Educational History

Child's school & district _____ Grade: _____

24) How is your child performing academically?

25) Does your child receive special services?

26) How does your child interact with others?

Parent Goal Planning

In 6 months my child will:

1. _____
2. _____
3. _____

Please provide any additional information that may be helpful in the evaluation or remediation of your child's speech and language deficits:

Name of person completing form: _____

Relationship to child: _____

Signature: _____