THE WALDRON COLLEGE OF HEALTH AND HUMAN SERVICES
Radford University Speech-Language and Hearing Clinic
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Child Speech and Language Case History Form

General Information:

Date form completed:_____

Child's name:_____ Date of birth:_____

Gender: _____ Race/Ethnicity: _____

Address:_____ Phone:_____

City: _____ Zip: _____

Person completing form:_____ Relationship to child:_____

Does the child live with both parents? _____

Parent/Guardian #1 name: _____ Age:_____

Parent/Guardian #1 occupation: _____ Business phone:_____

Parent/Guardian# 2 name:_____ Age:_____

Parent/Guardian #2 occupation:_____ Business phone:_____

Referred by:_____ Phone:_____

Address:_____

Pediatrician:_____ Phone:_____

Address:_____

Family Doctor:_____ Phone:_____

Address:_____

Brothers and Sisters (Please include names and ages):

_____

_____

_____

_____

What language does the child speak? What is the child's primary language?

_____
_____
_____

What languages are spoken in the home? What is the primary language spoken?

_____
_____
_____
_____

With whom does the child spend most of his or her time?

_____
_____
_____
_____

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

_____
_____
_____
_____

Describe the child's speech-language problem:

_____
_____
_____
_____
_____

When was the problem first noticed? By whom?

_____
_____
_____

What do you think may have caused the problem?

_____
_____

Has the problem changed since it was first noticed? (If yes, please describe):

_____
_____

Is the child aware of the problem? If yes, how does he or she feel about it?

_____
_____
_____

What changes in the child's speech-language or hearing have you noticed since that time?_____
_____
_____
_____

Have any other speech-language specialists seen the child? Who and when? What were their conclusions or suggestions? **Or Please list persons of clinics you have consulted about the problem?**

Date **Name and Addresses** **What were you told?**

_____
_____
_____
_____
_____
_____

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

_____
_____
_____
_____
_____
_____

Has the child ever had speech or language treatment? If yes, what was done in treatment?

_____
_____
_____
_____

Are there any other speech, language, or hearing problems in the family? If yes, please describe.
_____
_____
_____
_____

Maternal side of family? Yes_____ No_____

Paternal side of family? Yes_____ No_____

Both sides of the family? Yes_____ No_____

Speech, Language, and Hearing History

Does the child have any trouble sucking and/or nursing? Please describe:_____
_____
_____
_____

Does it take an excessive length of time to drink a bottle?_____
Is there any regurgitation of liquids or solids through the nose?_____
Does the child have difficulty chewing meats?_____ While eating, does the child show signs of choking and/or gagging? Please describe:
_____
_____
_____
_____

At what age did the infant babble and coo?_____

At what age did the child say his/her first words?_____

At what age could the child identify objects by pointing?_____

At what age did the child follow simple directions such as "Give it to mommy?_____
_____
_____
_____

At which age did the child begin to use two-word phrases?_____

Did speech learning ever seem to stop for a period of time? Please describe:_____
_____
_____
_____

Do you question the child's ability to understand directions and conversation? If yes, why?_____
_____
_____

How well is the child understood by: parents_____, Brothers or sisters_____, playmates_____, and other adults_____

Does the child get stuck and/or repeat sounds or words? If yes, please describe:
_____
_____
_____

Do you think the child hears adequately?_____ Do you think his/her hearing is constant or does it vary?_____

Does the child wear hearing aid(s)_____ Which ear?_____

What kind?_____

When did the child begin to wear a hearing aid (s)?_____

Who recommended it?_____

Does amplification help?_____

Does the child's voice seem normal to you? If no, please describe:
_____
_____
_____

What do you think causes his/her voice to sound unusual?_____

Prenatal and Birth History

Mother's general health during pregnancy (illnesses, accidents, medications, etc.)
_____
_____
_____
_____

Length of pregnancy:_____ Length of labor:_____

General condition: _____ Birth weight:_____

Circle type of delivery: head first feet first breech Caesarian

During this pregnancy did the mother have any of the following:

Check if applicable		Month of Pregnancy	Hospitalization Necessary?	Check if applicable		Month of Pregnancy	Hospitalization Necessary?
	Excessive vomiting				Kidney Disease		
	Bleeding				X-Rays		
	Swelling				Rh-negative		
	High Blood Pressure				Smoking		
	Low Blood Pressure				Diabetes		
	High fever				Hallucinogens		
	Convulsions				Toxemia		
	Excessive weight gain or loss				Surgery		
	Virus Infection				Accidents		
	German Measles (rubella)				Medications		
	Heart Condition				Miscarriage		
	Asthma				Other (specify)		
	Thyroid condition						

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

_____
_____
_____
_____
_____
_____
_____

Birth weight?_____Were instruments used?_____Bruises?_____

Apgar score at 1 minute:_____At 5 minutes:_____

Were there health problems during the first 2 weeks of infancy? _____
_____

How long did the child remain in the hospital nursery?_____
Which hospital?_____

Check all that applied:

_____Jaundice	_____Transfusion	____Feeding difficulty
_____Difficulty Breathing	_____Tube	____Oxygen
	_____Medications	____Intravenous fluids
_____Convulsions	_____Infection	
_____Incubator or Isolette	_____Hemorrhage	

Medical History:

Provide the approximate ages at which the child suffered the following illnesses and conditions:

Allergies:_____ Asthma:_____ Chicken Pox:_____
Colds:_____ Convulsions:_____ Croup: _____
Dizziness:_____ Draining Ear:_____ Ear Infections: _____
Encephalitis:_____ German Measles:_____ Headaches:_____
High Fever: _____ Influenza: _____ Mastoiditis:_____
Measles: _____ Meningitis: _____ Mumps: _____
Pneumonia: _____ Seizures: _____ Sinusitis:_____
Tinnitus: _____ Tonsillitis:_____ Other: _____

Has the child had any surgeries? If yes, what type and when (e.g. tonsillectomy, tube placement, etc)?

_____
_____
_____

Describe any major accidents or hospitalizations:

_____
_____When?_____
_____
_____
Where?_____
_____
_____

Is the child taking any medications? If yes, identify.

_____
_____
_____

Have there been any negative reactions to medications? If yes, identify.

_____
_____
_____

Does the child have any allergies that have been identified? If yes, please describe.

_____
_____
_____

Did the child have three or more ear infections (earaches, running ears) during the first year of his/her life?

_____
_____

Has the child's eardrum ever ruptured?_____

Has the child ever had tubes placed in his/her ears?_____
When?_____

Has the child had an ear infection within three months prior to this evaluation?_____

Have there been any changes that might have been stressful for your child (past and/or present, e.g. hospitalization, death of someone close, numerous moves, separations, divorce?_____

_____

Developmental History:

Provide the approximate age at which the child began to do the following activities:

Held head erect:_____ Rolled from back to stomach:_____
Played with hands:_____ Reached for objects:_____
Crawl:_____ Pulled self to sit:_____ Sit:_____
Pulled self to stand:_____ Stand:_____ Walk: _____
Walked alone:_____ Tied shoes:_____ Feed Self: _____
Dress self: _____

Use toilet (toilet trained):_____
Use single words (e.g., no, mom, doggie, etc.):_____
Combine words (e.g., me go, daddy shoe, etc):_____ Name simple objects (e.g., dog, car, tree, etc.):_____
Use simple questions (e.g., Where's doggie? etc.):_____
Engage in conversation:_____
Does the child lose balance or fall easily?_____

Does the child have difficulty walking, running, or participating in other activities which require small or large muscle coordination?

_____
_____
_____

Are there or have there ever been any feeding problems (e.g., problems with sucking, swallowing, drooling, chewing, etc.? If yes, describe.

_____
_____
_____

Describe the child's response to sound (e.g., responds to all sounds, responds to loud sounds only, inconsistently responds to sounds, etc.).

_____

Social and Education History:

Does the child tend to play alone, with other children, or adults?

_____

Ages of playmates:_____ How does the child get along with other children?_____
With adults?_____

Is it difficult to discipline your child? (Explain as fully as possible.)_____
_____
_____

Would you describe the child as happy or unhappy?_____

Is the child unusually quiet?_____ Unusually active?_____

Does your child have difficulty concentrating?_____
_____
_____

Difficulty sleeping?_____

Does anything else about the child's behavior concern you?_____
_____
_____
_____

What are the child's favorite play activities?_____

Did the child attend nursery or day care school? If so, where?_____

School:_____ Grade:_____
Teacher(s): _____
How is the child doing academically (or pre-academically)?
_____
_____

_____

Does the child receive special services? If yes, describe.

_____
_____
_____

How does the child interact with others (e.g., shy, aggressive, uncooperative, isolated, etc.)?

_____
_____
_____

If enrolled for special education services, has an Individualized Educational Plan (IEP) been developed? If yes, describe the most important goals?

_____
_____
_____
_____
_____

Provide any additional information that might be helpful in the evaluation or remediation of the child's problem. (Please use back of page or add additional sheets if needed).

Thank you for your help. Your insights will enable us to do our best for you and the child.