SALUS UNIVERSITY
Speech-Language Institute

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CHILD CASE HISTORY FORM

Please answer the following questions as best you can and return the form to the clinic. If there are some questions which you cannot answer, leave them blank.

I. ROUTINE INFORMATION

Name of your child: _____

DOB: _____ Age: _____ Gender _____

Name of parent(s)/guardian: _____

Address: _____

Primary Phone: _____ ☐ Cell ☐ Home ☐ Work

Secondary Phone: _____ ☐ Cell ☐ Home ☐ Work

E-mail address: _____

Name of person giving information: _____

Relationship: _____

Health Insurance: _____

Policy Number: _____

Ethnicity*: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other/Declined to specify

Race of the child*_____

Race: 0 = Not reported/Declined to Specify 1= American Indian/Alaska Native
2 = Black/African American 3 = Asian/ Pacific Islander 4 = White/Caucasian

* This information is requested to be used solely for the purpose of describing caseload diversity. Your response will not affect consideration of your child's application.

II. PRESENT SPEECH AND LANGUAGE STATUS

Is your child currently speaking or attempting to speak? ☐ **Yes** ☐ **No**
If yes, approximately how much of your child's speech is understood by the following (please circle):

Parents/Caregivers: ☐ 25% or less ☐ 50% ☐ 75% ☐ 90-100%

Unfamiliar people: ☐ 25% or less ☐ 50% ☐ 75% ☐ 90-100%

List sounds or words that your child pronounces incorrectly: _____

_____

_____

What is your child's reaction when his/her speech is not understood? _____

_____

_____

_____

Select the skill(s) that best describes your child:

☐ responds to only loud sounds

☐ responds only to sounds in the home

☐ understands single words

☐ understands simple sentences

☐ understands complex directions and sentences

☐ uses only gestures

☐ makes no vocal sounds

☐ babbles only

☐ says single words

☐ speaks in simple sentences

☐ uses complex sentences

What kind of progress or changes have you seen in your child's speech and language skills over the past six months?

_____

_____

_____

III. DEVELOPMENTAL HISTORY

A. Birth History

How many weeks gestation? _____ Birth weight? _____

Any complications during pregnancy, delivery, or immediately after birth?

_____

_____

_____

B. Growth

During infancy, did your child demonstrate any feeding or swallowing problems? _____

Please describe: _____

_____

Has your child increased in height and weight normally? _____ If not, please describe: ____

_____

_____

_____

C. Motor

Age of sitting up _____ Age of crawling _____ Age of walking _____

Does your child frequently do any of the following in regards to mealtime? (Check any that apply):

☐ Cough/choke on liquids

☐ Cough/choke on food

☐ Avoid certain textures/foods (“picky eater”)

Has your child ever: ☐ Used a pacifier ☐ Suck thumb

What type of cups does your child currently and efficiently use? (Check any that apply)

☐ Open cup ☐ Straw cup ☐ Sippy cup ☐ Bottle ☐ Other:

At what age did your child start feeding himself/herself? _____

Dressing himself/herself? _____ Become toilet-trained? _____

D. Speech Development

Did your child babble and coo during the first ten months? _____

At what age did your child start to use single words meaningfully? _____

At what age did your child start to combine 2-3 words into phrases? _____

IV. MEDICAL HISTORY

A. List diseases/conditions and their effects and severity: _____

_____

_____

_____

B. List significant injuries, ages and effects: _____

_____

_____

_____

C. List operations and ages for each operation: _____

D. Name of child's current pediatrician _____

Address _____

Phone _____

E. Please list any medication that your child is currently taking (name/dosage/schedule) _____

F. Does your child have any allergies or dietary restrictions? _____

V. SCHOOL HISTORY

Please complete all of the following that apply to your child:

	Name and Location	Age Entered	Dates
Preschool:			
Elementary School:			
Junior High:			
Senior High:			

VI. SPEECH-LANGUAGE HISTORY

Please list the names of other clinics or agencies where your child has been evaluated or treated for speech-language hearing difficulties. Please attach copies of any reports to this form.

Name	Location	Dates Evaluated/Treatment	Currently Rec. Services? Yes/No
1.			
2.			
3.			
4.			

Are there any other medical teams currently treating your child? Is your child receiving any other therapies aside from Speech therapy? Please list type and location/frequency.

Name Location Dates Evaluated/Treatment Currently Rec. Services?

1. _____
2. _____
3. _____
4. _____

VII. FAMILY AND SOCIAL HISTORY

Parent name _____ Age _____

Place of birth _____ Occupation _____

If not from birth, how long have you lived in the United States? _____

Native language(s) _____ Other language(s) spoken: _____

Education completed: ☐ Elementary/Middle ☐ High school ☐ College ☐ Other

Parent name _____ Age _____

Place of birth _____ Occupation _____

If not from birth, how long have you lived in the United States? _____

Native language(s) _____ Other language(s) spoken: _____

Education completed: ☐ Elementary/Middle ☐ High school ☐ College ☐ Other

Names and age of brothers and sisters _____

_____

Others in household _____

_____

Describe any family history of speech/language or hearing difficulties (e.g. learning disabilities, stuttering, articulation impairment, deafness, etc.) _____

_____

_____

What languages are spoken in your child's home or everyday environment? _____

_____

_____