
# Child Case History

**General Information**

Today's Date _____

Child's Name Date of Birth: Gender

Address: Phone:

City: Zip:

Mother's Name: Age:

Mother's Occupation: Business Phone:

Father's Name: Age:

Father's Occupation: Business Phone:

Does the child live with both parents?

If no, with whom does the child live?

Brothers and Sisters (include names and ages):

Child's Pediatrician: _____ Pediatrician's Phone Number: _____

Referred By: Phone:_____

Address:

Physician: Phone:

Address:

Other specialists who have seen the child:

What language(s) does the child speak?

How does the child primarily communicate (select)?

Gestures Sign Language Single Words Short Phrases Sentences

Describe the child's speech and/or language concerns.

When was the problem first noticed?

Who first noticed the problem?

Since you first noticed the problem, what changes have you observed in your child's speech and/or language?

Is the child aware or concerned by the problem?

If yes, how does he or she feel about it?

What have you done to help your child with the problem?

Describe other speech and/or language problems in the family.

**Prenatal and Birth History**

Describe mother's general health during pregnancy (illnesses, accidents, prescription and non-prescription medications, etc.).

Length of pregnancy: Length of labor:

Child's general condition: Birth weight:

Select type of delivery (select): head first feet first breech Cesarean

Were forceps used?

Child's length of stay in hospital:

Describe any unusual conditions that may have affected the pregnancy or birth.

**Medical History**

Child's general health is judged to be: Good Fair Poor

Please check if your child has experienced the following illnesses and conditions.

| | | |
|---|---|---|
| Adenoidectomy | Asthma | Allergies |
| Chicken pox | Colds | Convulsions |
| Croup | Draining ear | Dizziness |
| Ear infections | Epilepsy | Encephalitis |
| German measles | Headaches | Hearing loss |
| Heart problems | High fever | Influenza |
| Measles | Mastoiditis | Meningitis |
| Mumps | Noise Exposure | Pneumonia |
| Seizures | Sinusitis | Tinnitus |
| Tonsillitis | Tonsillectomy | Visual Problems |
| Other | Glasses | |

List child's current medication(s) and dosage(s).

Describe any major accidents, surgeries, or hospitalizations the child has had.

**Developmental History**

Write the approximate age when the child began to do the following.

Crawl Sit Stand Walk Feed Self

Dress Self Use toilet Use single words Combine words

Name simple objects Use simple questions Engage in a conversation

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

Describe any feeding problems (e.g., problems with sucking, swallowing, drooling, chewing, etc.) your child has had.

Does your child:

Respond to many sounds? Yes or No

Respond to the sound of the telephone bell? Yes or No

Respond to the sound of human voices? Yes or No

Respond to loud sounds only? Yes or No

Respond to sounds inconsistently? Yes or No

Seem to ignore sounds willfully? Yes or No

Do you suspect any problems with hearing? Yes or No

**General Behavior**

Does the child eat well? Sleep well?

How does the child interact with other family members?

Is the child: attentive extremely active restless

Does the child bang his/her head, rock, or spin?

Does the child play by him/herself?

How does the child interact with other children?

Does the child lose his/her temper?

With whom does the child spend most of the day?

**Educational History**

School or Preschool: Grade:

Describe any special services your child receives.

* If enrolled for special education services please provide a copy of their most current Individualized Educational Plan (IEP) or Individual Family Service Plan (IFSP).

Please add any additional information you feel might be helpful in the evaluation or treatment of the child's problem.

Person completing the form:

Relationship to the child: