TalkTime
Speech Language Therapy

20 Elm Street | Morristown, NJ 07960 | 973-271-8387
info@talktimenj.com | www.talktimenj.com

CASE HISTORY FORM - A

GENERAL INFORMATION:

Child's Name: _____Date of Birth: _____
Home Address: _____
City: _____Zip Code: _____
Name of current preschool/daycare:_____

Mother's Name: _____
Email Address: _____Home Phone: _____
Cell Phone: _____Business Phone: _____
***Please asterisk (*) the best number where we may reach you.**
Father's Name: _____
Email Address: _____Home Phone: _____
Cell Phone: _____Business Phone: _____
***Please asterisk (*) the best number where we may reach you.**

Who does your child live with? (Check all that apply.)

□both parents
□mother only
□father only
□parent + stepparent
□grandparents
□foster parents
□other_____

Referred by: _____Phone: _____
Address: _____
Pediatrician: _____Phone: _____
Address: _____

How did you hear about us?
__ Pediatrician or other Professional
__ Family/Friend referral: _____
__ Found you online (indicate which website): _____
__ Parenting Magazine
__ Daycare/Preschool/School
Other: _____

Indicate any concerns you have for your child in the following area(s):

☐ Articulation	☐ Not talking yet	☐ Poor Memory
☐ Receptive Language	☐ Limited number of words	☐ Colors/Shapes
☐ Expressive Language	☐ Not putting words together	☐ Letters/Numbers
☐ Social Skills	☐ Basic Concepts	☐ Word Finding
☐ Auditory Processing	☐ Feeding difficulties	☐ Attention/Focus
☐ Stuttering	☐ Following simple directions	☐ Behavior

When did you first notice the problem(s) you indicated above? _____

_____

Are there any other speech, language, hearing, or learning problems in your family?

□ Yes □ No

If yes, please describe.

_____

_____

_____

PRENATAL and BIRTH HISTORY:

Did you have a normal pregnancy? □ Yes □ No

Length of pregnancy _____

Please list any complications: _____

_____

Was the baby's birth (please circle): **premature** **term** **late**

Describe your child's delivery and birth.

□typical □spontaneous □induced □Cesarean □breech □unusually long labor

Please list any complications:_____

_____

Length of labor: _____ Birth Weight: _____

What was your child's condition at birth?

☐	☐	☐	☐	☐	☐
typical	birth injury/defect	jaundiced	breathing problem	low birth weight	other _____

Please list any complications/unusual conditions that may have affected the pregnancy or birth?

_____

_____

MEDICAL HISTORY:

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

Asthma _____	Chicken pox _____	Colds _____
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)?

_____

_____

_____

_____

Describe any major accidents or hospitalizations.

_____

_____

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

_____

_____

_____

_____

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

_____

_____

DEVELOPMENTAL HISTORY

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

Crawl _____ Sit _____ Stand _____

Walk _____ Feed self _____ Dress self _____

Use toilet _____

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 have a history of feeding problems? If *yes*, check all that apply:

□ choking □ difficulty biting □ overstuffing mouth
□ poor nursing □ difficulty chewing □ difficulty swallowing

Is your child a messy or picky eater?
□ Yes □ No

Please list favorite foods.

_____
_____
_____

Please list food sensitivities:

_____
_____
_____

Does your child have trouble sleeping through the night?
□ Yes □ No

AUDIOLOGICAL HISTORY:

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

_____

_____

Please check the appropriate column:

	Y	N
My child has 3+ ear infections between birth and 12 months of age.		
My child has had at least one ear infection which lasted more than 3 months.		
My child has been evaluated by an audiologist who determined that his/her hearing is within normal limits. Date of screening: _____		
I suspect my child has a hearing problem		
My child prefers one ear over the other. If yes, which ear? (circle) **Right** or **Left**		
My child has had tubes in his/her ears. If yes, when? _____		
My child wears hearing aids. If yes, what type and for how long?		

SPEECH AND LANGUAGE HISTORY:

Did your child babble? □ Yes □ No
If yes, did he/she use a variety of sounds when babbling? □ Yes □ No

What were your child's first words?

_____

_____

Once your child started to use words, did he/she continue to add new words to his/her speaking vocabulary on a weekly basis? □ Yes □ No

Does your child have a history of using a word once or several times, and then never using it again? □ Yes □ No
If yes, please give examples.

_____

_____

_____

Is your child reluctant to communicate or become frustrated when trying to speak?
□ Yes □ No If yes, please describe.

_____

_____

_____

Is your child reluctant to imitate speech sounds or words? □ Yes □ No

Does it seem that your child has more difficulty producing understandable speech on some days and not others, or at certain times? □ Yes □ No
If yes, please describe.

_____
_____
_____

How would you describe your child's speech errors?
□ consistent □ inconsistent (change from word to word and/or day to day)

Approximately how much of your child's speech do you understand?
□less than 25% □25% □50% □75% □100%

Can people outside the family understand your child's speech?
□ Yes □ No

How would you describe the intonation and rhythm of your child's speech?
(Check all that apply.)

□smooth	□slow	□soft
□halting	□fast	□lacking in intonation
□choppy	□loud	□lacking in pitch changes

How does your child typically communicate with others? (Check all that apply.)

□talking (whether understandable or not)	□facial expressions
□gestures	□pulling/taking adult to what he/she wants
□signs	□crying
□pictures	□pointing
□Voice output speech device	Other_____

Does your child play and communicate well with his/her friends and family?
□ Yes □ No

Does your child seem to understand most of what you say or tell him/her to do?
□ Yes □ No

Does your child have difficulty following directions?
□ Yes □ No
If yes, please describe.

_____
_____

How many words does your child now use?
□0-20 □20-50 □100-150 □150-200 □More than 200

If your child uses phrases and sentences, how long are they on average?
□2 words □3 words □4 words □longer than 5 words

Does your child…? Please check the appropriate column:

	Y	N
Ask questions to gain information		
Understand vocabulary		
Use age-appropriate vocabulary		
Stay on subject in conversation		
Take turns when talking to someone		
Describe and explain		
Answer questions		
Have difficulty putting words together into a sentences		
Leave words out of sentences		
Use correct grammar such as plurals, verb tenses, pronouns		

What have you done in the past to help your child communicate? Is it effective?

_____
_____
_____

VOICE and FLUENCY:

Is your child's voice clear? □ Yes □ No
If no, please describe.

_____
_____
_____

Describe your child's voice. (Check all that apply.)

□nasal
□denasal (sounds like he/she has a cold)
□loud
□soft
□high-pitched
□low-pitched
□monotone
□breathy
□hoarse

Does your child talk smoothly without repeating sounds or words? □ Yes □ No
If no, does he/she have trouble getting words out? □ Yes □ No
If yes, please describe.

_____
_____
_____

SENSORY and MOTOR:

Does your child have any difficulty walking, running, sitting or other large motor skills?
□ Yes □ No
If *yes*, please describe.

_____
_____

Does your child tippy-toe walk?
□ Yes □ No

Is your child clumsy or does he/she fall easily?
□ Yes □ No

Does your child have low body tone?
□ Yes □ No

Does your child have difficulty with fine motor skills such as stacking, cutting and handwriting?
□ Yes □ No
If *yes*, please describe.

_____
_____

Is your child sensitive to certain textures of food or clothing?
□ Yes □ No
If *yes*, please describe.

_____
_____

Does your child dislike having substances on his/her hands such as glue or dirt?
□ Yes □ No

Is your child oversensitive to being touched or dislike being touched?
□ Yes □ No
If yes, please describe.

_____
_____

Check all that apply regarding your child.

□dislikes washing his/her face or hair
□dislikes haircuts
□spends too little time or too much time brushing his/her teeth
□does not demonstrate caution
□puts things in his/her mouth besides food
□chews on his/her clothes

BEHAVIOR:

Does your child typically display any of the following behaviors? (Check all that apply.)

□reduced or lack of interaction with others
□tantrums
□passive in interactions
□very active
□underactive
□inattentive
□refuses to perform tasks
□difficulty staying on task
□difficulty finishing tasks
□sensitive
□angry/acting out behavior
□frustrated
□shy

OTHER INFORMATION:

Are languages other than English spoken in the home?
□ Yes □ No
If *yes*, please list.

_____

Has your child had a previous speech-language evaluation?
□ Yes □ No
If *yes*, please list date(s) and results.

_____
_____
_____

Has your child had previous speech-language therapy?
□ Yes □ No
If *yes*, please list dates, setting(s) and therapist(s).

_____
_____
_____

If your child had speech-language therapy, what kind of progress did your child make? Please explain.

_____
_____
_____

Has your child been evaluated by any other professional? (Check all that apply.)

□occupational therapist (OT)
□physical Therapist (PT)
□neurologist
□developmental pediatrician (specialist)
□psychologist/psychiatrist
□educator/teacher
□geneticist
□physician
□other_____

Does your child have a diagnosis from any of the above professionals?
□ Yes □ No
If yes, please list date, professional, and diagnosis for each.

_____
_____
_____

What other concerns do you have about your child?

_____
_____
_____

What do you consider to be your child's greatest strengths?

_____
_____
_____

What do you hope to gain from this evaluation?

_____
_____
_____

Person completing this form: _____
Relationship to child: _____
Signed_____ Date: _____