TalkTime
Speech Language Therapy

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CASE HISTORY FORM - B

GENERAL INFORMATION:

Child's Name: _____ Date of Birth: _____

Home Address: _____

City: _____ Zip Code: _____

Name of current school: _____ Grade level: _____

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	☐ Stuttering	☐ Poor Memory
☐ Receptive Language	☐ Reading Fluency	☐ Attention/Concentration
☐ Expressive Language	☐ Reading Comprehension	☐ Loses place/Skips lines
☐ Social Skills	☐ Spelling	☐ Reversals of letters
☐ Auditory Processing	☐ Writing	☐ Motivation/behavior
☐ Slow Working	☐ General Learning	☐ Over-active

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 _____

First words _____

First sentences _____

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:

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 □ 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)
□gestures
□signs
□pictures
□Voice output speech device
□facial expressions
□pulling/taking adult to what he/she wants
□crying
□pointing
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.

_____

_____

AUDITORY PROCESSING and LEARNING:

Does your child have difficulty with any of the following? (Check all that apply.)

□memory tasks
□comprehension
□word retrieval
□hearing difficulties
□listening with background noise
□reading difficulties
□spelling/writing difficulties
□ phonologic/phonemic difficulties
□ learning difficulties
□remembering and following multi-step directions
□putting thoughts together
□difficulty learning or using new vocabulary
□auditory attention
□academic underachievement
□hypersensitivity to loud sounds
□word-finding difficulties
□auditory distractibility
□ organization and planning

Did your child have difficulty learning early academic skills such as matching, identifying same/different and/or knowing names of colors, shapes, numbers, and letters, spatial awareness words (under, between, next to), days of the week, temporal words (yesterday, tomorrow, next week, etc.)?

□ Yes □ No
If *yes*, please describe.

_____

_____

Does your child receive any services at school (IEP or 504 plan) or outside help? List all.
□ Yes □ No
If Yes, please explain.

_____

_____

_____

Can your child retell a simple story in sequence?
□ Yes □ No

Can your child identify steps to complete a simple task? (e.g., brushing teeth, setting the table)
□ Yes □ No

Did your child having difficulty learning nursery rhymes or the concept of rhyming?
□ Yes □ No

Does your child appear to attend to your face when listening?
□ Yes □ No

Does your child appear to become distracted easily when listening?
□ Yes □ No

Does your child appear to be confused with listening?
□ Yes □ No

Does your child appear to be particularly uncomfortable in noise (as compared to age-peers)?
□ Yes □ No

SENSORY and MOTOR:

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

_____

_____

Does (or did) your child tippy-toe walk?
□ Yes □ No

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

Does (or did) your child have low body tone?
□ Yes □ No

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

_____
_____

Is (or was) 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: _____