



**CHILD CASE HISTORY FORM**

**TODAY'S DATE:** \_\_\_\_\_ **PERSON COMPLETING:** \_\_\_\_\_

**I. Background information**

Child's Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Physical Address: \_\_\_\_\_

Email Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

Other Telephone Numbers: \_\_\_\_\_

If this is an evaluation, what questions would you like answered?

\_\_\_\_\_  
\_\_\_\_\_

**II. Family Information**

Parent Name(s): \_\_\_\_\_

Legal Status: \_\_\_\_\_ Parents Highest Level of School: \_\_\_\_\_

Family Members Residing in Household: \_\_\_\_\_

Siblings Not Residing in Household: \_\_\_\_\_

Languages spoken at home: \_\_\_\_\_

**III. Prenatal History**

Please describe those items which pertain to the mother's health during this child's pregnancy:

\_\_\_\_ Illnesses \_\_\_\_ Accidents \_\_\_\_ Infections \_\_\_\_ Medications \_\_\_\_ Alcohol/Drug Use

Please describe mother's health before, during and after pregnancy: \_\_\_\_\_

\_\_\_\_\_

**IV. Birth History**

Was your child full term, premature or late? \_\_\_\_\_ If premature, more than 3 weeks? \_\_\_\_\_

Was delivery vaginal, Cesarean, VBAC? \_\_\_\_\_ Child's birth weight? \_\_\_\_\_

Please describe any difficulties, medications or treatments at birth: \_\_\_\_\_

\_\_\_\_\_

**V. Medical History**

Child's Physician: \_\_\_\_\_ Address: \_\_\_\_\_

Has the child been seen by other medical specialists, such as a psychologist, neurologist, eye doctor, Ear  
Nose and Throat specialist or Audiologist? \_\_\_\_\_

Has your child had a hearing test? \_\_\_\_\_ When/where/results? \_\_\_\_\_

Is there a history of hearing loss in the family? \_\_\_\_\_

Child's age at first ear infection: \_\_\_\_\_ Child's age at last or most recent infection: \_\_\_\_\_ Total # \_\_\_\_\_

Has your child had any serious injuries or hospitalization? \_\_\_\_\_

\_\_\_\_\_

Does your child have any allergies? \_\_\_\_\_ Medications? \_\_\_\_\_

Does your child have any medical conditions? \_\_\_\_\_

Is your child on any medications? \_\_\_\_\_

**VI. Developmental History**

Please give approximate ages when your child accomplished the following skills:

Sitting up \_\_\_\_\_ Crawling \_\_\_\_\_ Walking \_\_\_\_\_ Self Feeding \_\_\_\_\_ Toilet Training \_\_\_\_\_

Babble \_\_\_\_\_ Use single words \_\_\_\_\_ Combine words \_\_\_\_\_ Be understood by all \_\_\_\_\_

Which hand does your child prefer to use? \_\_\_\_\_

Has your child ever stopped talking for any period? \_\_\_\_\_

Has your child ever had trouble walking, climbing, reaching or holding onto things? \_\_\_\_\_

Were there any difficulties with sucking, swallowing, breast or bottle feeding? \_\_\_\_\_

Does your child cough frequently when eating or drinking? \_\_\_\_\_

Did your child make transitions from baby foods to junior foods to table foods at expected times? \_\_\_\_\_

Does your child have any known impairment of the tongue, palate, nose, throat, ears, cheeks, gum or lips? \_\_\_\_\_

Has your child had a speech language evaluation or therapy? \_\_\_\_\_

Is there family history of any speech, language or learning problem? \_\_\_\_\_

Please describe your child's favorite activities: \_\_\_\_\_

Please describe your child's temperament and personality: \_\_\_\_\_

How does your child get along with family members and friends? \_\_\_\_\_

**VII. Educational History**

Child's Current School: \_\_\_\_\_ Current grade: \_\_\_\_\_

School Address: \_\_\_\_\_

Your child's current teacher(s): \_\_\_\_\_

Other specialists or professionals currently working with your child: \_\_\_\_\_

Has your child repeated any grades? \_\_\_\_\_ Has your child been evaluated in the schools? \_\_\_\_\_

Does your child have an Individual Education Program (IEP) or a 504 Accommodation Plan? \_\_\_\_\_

Describe the areas of support on the IEP or 504: \_\_\_\_\_

What are your child's feelings about school? \_\_\_\_\_

Describe your child's academic grades: \_\_\_\_\_

List the schools that your child has attended below:

School Name	Grade	Progress
_____	_____	_____
_____	_____	_____
_____	_____	_____

**VIII. Learning and Communication**

Please describe the learning or communication difficulty that brings your child to Cape Cod Speech and Language. If the difficulty is academic, please describe particular subjects that are challenging. If your child has used, or is using, a specialized reading programs, please describe. If your child's difficulty is in the language area, please note whether it is with talking, listening, reading or writing. If your child's difficulty is with speech production, please note specific sounds or describe. If the difficulty is with other aspects of communication (fluency of speech, voice quality, gesture, social skills, augmentative device use), please describe. If your child is coming for therapy, what are the goals? \_\_\_\_\_

Please describe your child's ability to attend and concentrate: \_\_\_\_\_

What strategies, techniques, programs or activities have appeared to help your child's difficulty? \_\_\_\_\_

Thank you for taking the time to provide this history about your child. The information will be especially helpful in getting to know your child. Please feel free to discuss in person, any aspect of your child's profile. Please feel free to add any additional written comments that you feel would be beneficial for us to know.

