Child Case History Form

The following information is for professional use and will be handled confidentially. This information will assist the speech language pathologist in completing your child's evaluation.

Please complete the following questions as fully and accurately as possible. If you are unable to complete a question, please leave it blank or you may call our office for assistance at (678)705-1221.

General Information

Name of person completing this form _____

Relationship to this child _____ Date completed_____

Child's Name_____
Last First Middle

Nickname (s) _____ Date of Birth_____ Age____ Sex: Male___Female___

Sibling Information
Name _____ Age____ Male____ Female____

Name _____ Age____ Male____ Female____

Name _____ Age____ Male____ Female____

Primary Language _____ Language spoken in the home_____

What language does the child speak? _____

Please indicate your primary concern about your child's speech and language skills: _____
_____
_____
_____
_____

Medical History

Please indicate if the child has experienced any of the following conditions (con't on next page):

Allergies Yes____ Explain_____
Autism Yes____ Explain_____
Attention Deficit Disorder Yes____ Explain_____
Asthma Yes____ Explain_____
Chicken Pox Yes____ Explain_____
Epilepsy Yes____ Explain_____

Seizures Yes____ Explain_____
High Fevers Yes____ Explain_____
Meningitis Yes____ Explain_____
Muscular Disease Yes____ Explain_____
Traumatic Brain Injury Yes____ Explain_____
Vision Problems Yes____ Explain_____
Other_____

Child's Primary Care Physician:_____

Has your child had an audiological evaluation (hearing test)? Yes____ No____ When_____

Where _____

Were the results normal? Yes ____ No____. If no, please explain_____

_____

Occurrence of ear infections Yes ____ If "yes", approximately how many ear infections to date_____

Has your child had any speech and language testing? Yes____ No_____, If, "yes", Where?_____

_____

Has your child had any Speech and Language Intervention: Yes_____ No _____ if "yes",

Where? _____

List any medications prescribed for your child _____
_____

If your child has had other significant medical treatment, please explain_____
_____
_____

Developmental History

Prenatal and Birth History
Length of pregnancy _____ Delivery Complications Yes____ No ____ Birth weight_____

(Please explain if any complications occurred)_____
_____
_____

Did the infant have any difficulty with breathing, crying, sucking, jaundice, convulsions, blood incompatibility, etc. (Please explain)_____
_____
_____

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A. Motor Milestones
Please indicate the age or approximate age at which the following occurred:

Crawled _____ Sat alone _____ Walked unaided_____ Fed self_____ Dressed self_____
Toilet trained _____ Cooing____ Babbling____ First words____

Vocabulary of approximately 50 words: Understood #_____ Expressed #_____

Two-word combinations #_____ (examples: *more milk, me do, no go*)

Short Sentences # _____ (examples: *Me want juice., Mommy do it.)*

B. Receptive and Expressive Language Skills
Please answer "yes" or "no" or "sometimes" to the following questions:

1. Does your child respond to his/her name? Yes____ No ____ Sometimes ____
2. Will your child get common objects when asked? Yes____ No ____ Sometimes ____
3. Does your child follow simple directions? Yes____ No ____ Sometimes ____
4. Will your child point to pictures as you name them? Yes____ No ____ Sometimes ____
5. Does your child label pictures? Yes____ No ____ Sometimes ____
6. Does your child ask questions? Yes____ No ____ Sometimes ____ (Please give Examples)
   _____
   _____
7. Does your child repeat or "echo" others' expressions? Yes____ No ____ Sometimes____
8. Does your child repeat questions or parts of questions rather than answering them? Yes____ No ____ Sometimes ____
9. Does your child **excessively** recite/repeat words from video tapes/DVDs, songs, or television programs? Yes____ No ____ Sometimes ____
10. Has your child said a word and few times, then never used it again? Yes____ No ____ Sometimes ____ If "yes", when? _____ What words?_____
    _____
11. Did language development seem to just stop? Yes____ No ____ Sometimes ____ If "yes", when?
    _____

How does your child indicate his/her needs/wants to you?_____
_____

How does your child indicate he/she does **not** want something or does not want to do something?
_____
_____
_____

What types of words/sentences does your child express independently? _____
_____

Child Case History Form

Behavioral Information

A. Infancy

Was a silent infant? Yes____ No ____ Sometimes ____
Was an inconsolable infant? Yes____ No ____ Sometimes ____
Very happy infant (rarely cried, did not desire interaction/affection)? Yes____ No ____ Sometimes ____
Other comments_____

B. Play

Prefers to play alone? Yes____ No ____ Sometimes ____
Plays poorly with other children or does not interact with others? Yes____ No ____ Sometimes ____
Frequently lines items in a row? Yes____ No ____ Sometimes ____
Protests if line is interrupted? Yes____ No ____ Sometimes ____
Holds (clutches) items for extended periods of time? Yes____ No ____ Sometimes ____
Frequently counts (objects, items, actions etc) Yes____ No ____ Sometimes ____
Has unusual interest (strips of paper, electrical cords etc.)? Yes____ No ____ Sometimes __
Spins objects? Yes____ No ____ Sometimes ____
Other comments _____
_____

C. Conduct

Is difficult to manage? Yes____ No ____ Sometimes ____
Has a behavior problem? Yes____ No ____ Sometimes ____
Displays temper tantrums? Yes____ No ____ Sometimes ____
Consistently has a catastrophic reaction when told "no"? Yes____ No ____ Sometimes ____
Discipline is ineffective? Yes____ No ____ Sometimes ____
Is overly active? Yes____ No ____ Sometimes ____
Has a short attention span? Yes____ No ____ Sometimes ____
Is aggressive towards self? Yes____ No ____ Sometimes ____
Is aggressive towards others? Yes____ No ____ Sometimes ____
Is destructive with objects? Yes____ No ____ Sometimes ____
Other comments _____
_____

D. General

Is withdrawn? Yes____ No ____ Sometimes ____
Rocks back and forth? Yes____ No ____ Sometimes ____
Acts as if deaf? Yes____ No ____ Sometimes ____
Covers ears with hands? Yes____ No ____ Sometimes ____
Has limited eye contact? Yes____ No ____ Sometimes ____
Has difficulty with change/transitions? Yes____ No ____ Sometimes ____
Other comments _____
_____

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Education Information

Is your child currently enrolled in school? Yes/ No
If yes, school name and days attended:_____
Is yes, what grade/classroom level:_____

Supportive Services

What other services is your child <u>currently</u> receiving both in-school and out of school? Please enclose a copy of the child's most recent IEP or IFSP and Therapy goals from each area that is checked.

Service/Therapy	Location	Minutes/Week
☐ Early Intervention Services	☐ School ☐ Home	
☐ Speech and/or language therapy	☐ School ☐ Home	
☐ Occupational and/or Physical Therapy	☐ School ☐ Home	
☐ Vision services in school	☐ School ☐ Home	
☐ Hearing services	☐ School ☐ Home	
☐ Other	☐ School ☐ Home	

Please describe your child's personality:_____
_____
_____

Please feel free to indicate any questions or concerns that you would like to specifically discuss at your initial appointment.

1._____

2. _____

3. _____

4._____

5._____

How did you hear about *Communicate to Connect Therapy, LLC*?

- ○ Referral
- ○ Internet
- ○ Inservice
- ○ Other: _____

Thank you for taking the time to complete this form.