



CHILD CASE HISTORY FORM – MAIL OR FAX TO 888-317-8302

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.

